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Technical notes: Special Considerations for Programming in Unstable Situations

Introduction

Purpose

The Technical Notes: Special Considerations for Programming in Unstable Situations have been prepared for UNICEF staff and others who seek to assist children and women in emergencies. Their purpose is to help you identify and prioritise needs of children and women in unstable situations, and to design and implement interventions to support them in the most efficient and effective manner – building on and strengthening the capacities of families, communities and essential social services systems as much as possible. Its mandate is to keep the best interests of the child at the forefront of all situations.

The Technical Notes are designed as “resource material” to turn to for general guidance or specific information, and will be reviewed regularly. They are line with the principles of mainstreaming outlined during the 1998 Consultation of UNICEF Representatives convened in Martigny, Switzerland and the ensuing process of capacity building for a more effective and predictable humanitarian response within the overall framework of country programme processes. The Technical Notes are meant to provide guidance on programming consideration in unstable situations and should be consulted jointly with UNICEF’s Core Corporate Commitments (CCCs) and the Programme Planning Manual.

Structure

To make the Technical Notes user−friendly, the chapters have been placed on both CD−ROM and the UNICEF intranet (to be hypertext linked to the PP Manual). During conversion to the electronic format, efforts have been made to create a platform that is efficient and not graphic−intensive, in order to ensure that it can be easily uploaded to any computer.

The table of contents is divided into nineteen chapters presented in an order following the structure of the CCCs as outlined in the Executive Board Document E/ICEF/2000/12. Many are accompanied by annexes containing specific technical information, references to key documents and preliminary assessment tools/checklists, or elaborate certain issues in more detail. Within each chapter and annex, links have been created to headings, sub−headings and panels to allow for a ease of access and browsing in specific sections.

Overall Principles

Current situation analyses and global early warning indicators suggest an alarming increase in the number, scale, complexity and duration of emergencies in many regions of the world today. The consequences of such unstable environments and crises have been no less than catastrophic. This increasing impact is reflected in the severe social, cultural, political and economic disruption and dislocation facing the most vulnerable of affected communities whose wellbeing is at risk. In the midst of these crises, children and women are not only incidental victims but increasing targets of willful violence and abuse, and denied access to basic services and essential relief supplies.

The increasing complexity and unpredictable nature of emergencies and conflicts likewise demands the greater support of field offices and staff. Therefore, these Technical Notes are meant to be more than just a reference or a set of policies and procedures. They are designed as a support system for staff in the field during critical phases of a crisis. They provide an outline of UNICEF’s role in the programmatic sectors of response, and provide guidelines and strategies on how to provide assistance and advocate on behalf of women and children. In addition to technical information, they are resources for further guidance, and, most importantly, provide suggestions for utilising and developing the human capacity and resources of local
It is asserted that all strategies and actions during crises can be integrated within the country programme framework and are based upon principles of mainstreaming and full integration of emergency response into country programme planning processes – as articulated during the Martigny Consultation – initiating with an assessment of needs appropriate to the specific situation, population and cultural context, followed by implementation of effective and flexible response strategies and actions.

Furthermore, activities undertaken in any situation should respect the two fundamental tenets behind all UNICEF actions, namely the Convention on the Rights of the Child (CRC) and a commitment to human rights–based programming. The following basic principles are fundamental to all UNICEF emergency operations and should be applied in all circumstances:

- the best interest and protection of the child;
- the family focus;
- the development approach of local involvement, capacity–building and sustainability;
- the integrated approach based on the interrelationship and complexity of factors impacting women and children;
- the importance of collaboration and coordination with partners;
- the safety and security of staff.

Chapter 1. Protecting and Promoting Health

Rationale

General Aims

Prevent mortality and reduce morbidity and suffering among children and women in the “onset” phase of an emergency, when health threats are greatest and service capacity is weakest.

Assure that the quick restoration of peripheral health services and public health programmes contribute to a sustainable postemergency health care system.

Thousands of children are killed each year as a direct result of armed conflict and natural disasters. However, many more die from the increased rates of malnutrition and disease that typically accompany such emergencies. Infectious diseases are the biggest killer of children and young adults; they account for more than 13.3 million deaths a year, one in two deaths in developing countries. (WHO 1999. Report on Infectious Diseases, Removing Obstacles to Healthy Development).

The interruption of food supplies, the destruction of crops and agricultural infrastructure, the disintegration of families and communities, the displacement of populations, the disruption of health services, and the breakdown of water and sanitation systems all take a heavy toll on the health and nutrition of children. Many die as a result of severe malnutrition, while others become unable to resist common childhood diseases and infections. Those families already most disadvantaged are most vulnerable in times of emergencies. The health problems that they suffer from are of an increased incidence and severity. Measles, diarrhoeal diseases, and acute respiratory infection, combined with malnutrition, are the most common child killers in emergencies. Other deadly threats in endemic areas include malaria, cholera and epidemic dysentery/shigellosis, typhoid fever, meningitis and HIV/AIDS.

The increased incidence and severity of disease frequently occurs at a time when health services are least able to cope. Service capacity may be disrupted due to damage to health infrastructure, equipment and supplies and the permanent or temporary loss of staff. Preventive, curative and rehabilitative health care services – including child immunization – may be severely affected. When there are services available, they
are often being provided by a range of organizations, subject to few of the controls and supervision that exist in non–emergency situations.

Guiding Principles

Integrated primary health care approach: Such an approach strongly emphasizes preventative over curative care, and recognizes the importance of various non–medical factors to the health of emergency–affected populations. Foremost are security and protection, education, shelter, water supply, environmental sanitation, safe hygiene practices and adequate and appropriate food.

Adaptive response: Emergency health interventions must adapt and respond to rapidly changing needs and priorities over the course of an emergency. This requires a monitoring and surveillance system to be able to react and respond to needs.

Local leadership: It is critical that emergency–affected populations, including displaced and refugee populations, be given responsibility for their own health from the outset of an emergency health programme. Services must be operated with, rather than for, the affected population, with their active participation in their design, delivery and monitoring. If not, health care services will be less responsive to local needs, may be distrusted by the population, and are likely to collapse when key outside personnel leave.

Coordination: All emergency health interventions must be coordinated to ensure effective use of available resources and supplies to address the priority needs of all groups. Strategies, services and treatment schedules should be standardized as much as possible. Appropriate guidelines should be provided to all engaged in health–related activities.

UNICEF collaborates closely with the World Health Organization (WHO) and other UN Agencies as well as non–governmental organizations (NGOs) and the International Committee of the Red Cross (ICRC). The Consolidated Appeal Process (CAP) provides a coordinating tool to address health issues in humanitarian emergencies.

A large number of NGOs have set standards of health in a coordinated fashion, constituting The Sphere Project. The Sphere Project provides guidelines for Minimum Standards in Disaster Response, including health. These standards are a practical expression of the principles and rights embodied in the Humanitarian Charter, namely: requirements for sustaining the lives and dignity of those affected by conflict, as reflected in international human rights law, humanitarian and refugee law.

National Capacity Building: Local health personnel should be given maximum support and existing systems should be reinforced to meet emergency needs. Large numbers of expatriate doctors and massive inputs of drugs are often not needed and should be used only when necessary in developing local capacity while assuring essential services.

Sustainability: Health services during the acute emergency period should be planned – and resources used – to lay the foundation for a sustainable post–emergency health system. New long–term programmes should be initiated only if they will be able to be sustained (with adequate personnel and financing) after the ending of the emergency operation.

UNICEF’s Core Corporate Commitments in Health: UNICEF addresses the issue of humanitarian response through a set of Core Corporate Commitments (CCCs), in which capacities to forecast and respond to crises are mainstreamed into the programming and operational approach of UNICEF at country, regional and global levels.

To ensure the provision of the most basic health care services for children at the onset of an emergency, UNICEF will always guarantee, wherever appropriate, emergency measles immunization, Vitamin A distribution and the provision of essential drugs for the treatment of the most common childhood diseases.
Identifying Priorities

A child-focused needs assessment should be conducted at the outset of an emergency to identify critical health priorities, including the resources and know-how available at the UNICEF Country Office. This would normally cover current child health status, health service capacity and emergency response programmes already under way. (Panel 1 provides a general assessment checklist).

Sources of information include hospitals, clinics, and other facilities, special medical relief teams, community leaders, and community health workers. Informal discussions and focus group sessions with the affected population are also important. Much information can be gathered by simple observation, for example, on environmental health conditions.

The initial assessment should be followed as soon as possible with the establishment of a simple system designed to provide regular information concerning the health status of the affected population.

Field-Level Strategies and Actions

Although UNICEF emergency field-level actions are situation-specific, determined by need and the complementary capacities of UNICEF and its partners, as defined by the CCCs, the framework presented in Panel 2 serves as an overall guide.

These field-level health strategies and attached annexes are limited to the ‘onset’ and ‘ongoing crisis/early rehabilitation’ stages of an emergency. Pre- and post-emergency measures should be part of regular UNICEF country programmes and are beyond the scope of this handbook.

Measures in other sectors necessary to ensure good health and prevent disease, including reducing child malnutrition, ensuring adequate water supplies and environmental sanitation, and providing shelter, clothing and basic household items, are found elsewhere in the handbook.

Assure communicable child disease control measures

Preventing and controlling communicable diseases are life-saving activities in the initial stages of an emergency. Critical measures include the following:

Measles immunization: Measles is a major childhood killer in developing countries, accounting for about 900,000 deaths a year. (WHO, 1999. Report on Infectious Diseases. Removing Obstacles to Health Development.)

Absolute priority must be given to immunizing children against measles as quickly as possible through a carefully managed emergency vaccination campaign with attention to the following:

• High coverage – close to 100 percent – is necessary to prevent an outbreak, with priority to the 6–59 months age group and especially children in the first year of life (i.e. aged 6–11 months). Older children, up to 15 years of age, could be included, depending on previous immunization history and the epidemiology of the disease.

• Where access to specific populations is difficult, and continued access is uncertain, oral polio vaccine (OPV) and other EPI antigens may be included in an initial emergency campaign, provided sufficient resources are available and the measles vaccination would not be delayed.

• The integrity of the cold chain must be assured to prevent vaccines losing their potency as a result of inadequate storage and handling.

• Self-disabling syringes must always be used for immunization to avoid the risk of transmitting diseases such as HIV and hepatitis B.
• Full EPI operations should be re-established in line with national protocols as soon as the situation permits.

Please refer to Annex 2 for further details on immunization in emergencies.

**Vitamin A supplementation:** Vitamin A deficiency is associated with increased incidence, duration and severity of diarrhoea, measles, acute respiratory infection and increased mortality. In populations living in crowded, unsanitary conditions, vitamin A supplements should be provided to all children under the age of five as a major priority. These should normally be administered, as per WHO recommendations, at the same time as the measles vaccination.

• In a mass campaign, the reusable multidose dispensers with oily vitamin A solution in bottles may be particularly appropriate, provided timely delivery can be assured.

• Using the most common concentration of 100,000 IU/ml, two one-half millilitre squirts are given for a child 6–11 months of age, and four for a child over 12 months of age.

• Where 200,000 IU capsules are used, approximately half the contents of a capsule is given to a child 6–11 months of age, and a whole capsule for a child over 12 months. In a prolonged emergency, supplements may need to be provided on a continuing basis every 4–6 months.

Please refer to Annex 2 for further details on vitamin A supplementation in emergencies.

**Management, control and prevention of diarrhoea and dehydration:** Diarrhoeal diseases claim nearly 2 million lives a year among children under five. Overcrowding, poor water and sanitation and hygiene will inevitably lead to a high incidence of diarrhoeal disease. Measures to effectively manage cases of diarrhoea and dehydration should be a priority at the outset of an emergency. Emphasis should be on promoting correct case management at first-level health facilities, among community-based practitioners and among household caregivers through:

• ensuring the availability and regular supply of oral rehydration salts (ORS), and necessary supplies and equipment for treating severe dehydration cases at designated centres;

• ‘crash’ orientation of health workers on oral rehydration therapy (ORT), recognizing dysentery and cholera, and the appropriate use of antimicrobials for cholera and dysentery;

• ‘crash’ educational outreach targeting household caregivers on diarrhoea management, including utilization of home-based solutions, feeding and how to recognize and seek medical help for serious cases.

Case management must be accompanied by preventive measures promoting proper personal, household and food hygiene, encouraging breastfeeding, and improving water and environmental sanitation conditions.

Please refer to Annex 3 for further details on diarrhoeal disease control in emergencies, and to Annex 4 for additional information on containing outbreaks of cholera, dysentery and typhoid fever.

**Management, control and prevention of acute respiratory infections**

Overcrowding and inadequate shelter and protection will inevitably lead to a high incidence of respiratory infections among children. In developing countries, 25 to 30 per cent of deaths among children under five are caused by acute respiratory infections (ARI) and 90 per cent of them are attributable to pneumonia. Measures to ensure the effective management of cases of acute respiratory infection, particularly pneumonia, should therefore be a priority at the outset of an emergency. Emphasis should be on promoting correct case management at first-level health facilities and educating parents and other caregivers.

Focus should be on the following:

• ensuring the availability and regular supply of WHO-recommended antibiotics for the treatment of acute respiratory infections;
• ‘crash’ orientation of health workers on the recognition and appropriate, standardized treatment of child pneumonia and other acute respiratory infections based on WHO protocols;

• ‘crash’ educational outreach targeting household caregivers on recognition of ARI and the importance of early referral.

Clinical case management must be supported by encouraging breastfeeding, ensuring immunization, improving shelter and ensuring adequate warmth (heating, clothing and blankets).

Please refer to Annex 5 for further details on the control of acute respiratory infections in emergencies.

Management, control and prevention of other endemic communicable diseases: Emergencies can also create conditions favourable to the spread of other communicable diseases already endemic to the area. Malaria is a major threat in tropical areas, populations from areas of marginal transmission moving through or settling in endemic areas.

Malaria kills over one million people a year, mostly young children. In Sub-Saharan Africa, malaria accounts for one in five of all childhood deaths. In such situations, prevention of infection and correct management of cases are an immediate priority.

Please refer to Annex 7 for further details on the management and control of malaria, meningococcal meningitis, yellow fever, Japanese encephalitis, and tuberculosis, and refer to Annex 4 for further information on cholera, epidemic dysentery/shigellosis and typhoid fever.

Assure Reproductive Health Care

The problems caused by complications in pregnancy and delivery, and by unwanted and unsafe sex, are exacerbated by the disruption of the social network and the breakdown in support systems, the increase in sexual violence and the disruption in health services that accompany many emergencies.

Interventions covering pregnancies, deliveries and complications for mothers and newborns should be organized as soon as feasible in an emergency.

The essential safe motherhood services should include the following:

• Establishment of facilities equipped and staffed for essential obstetric care. Services can be provided in general health clinics, hospitals or in a mobile clinic during ongoing migration, until specific facilities are established.

• Immunization of women of childbearing age against tetanus should be carried out in situations where sanitary conditions are poor or the majority of deliveries are without trained support.

• Malaria is a particular risk to women during pregnancy. WHO recommends that all pregnant women in high-risk malaria areas should take antimalarial drugs to prevent infection.

• Development of a referral system to nearest facility where emergency obstetric care can be provided for women who require it. Local health centres and hospitals may need upgrading or extra support to handle the increased caseload. Around-the-clock transport should be arranged to handle referrals and each pregnant woman should be helped in establishing a referral plan well before a complication arises.

• For female survivors of rape and other forms of sexual violence, ensure adequate comprehensive care, including counselling.

Women’s input should be sought on the planning and provision of care, starting in the initial phase of the emergency, if possible, and continuing throughout its duration.

Please refer to Annex 8 for further guidelines on assuring reproductive health care in emergencies.
Control STD/HIV/AIDS Infections

The risk of a rapid spread of sexually transmitted diseases (STDs), including HIV/AIDS, increases dramatically in emergencies, as military activity, population movements, sexual violence and the breakdown of established social norms all increase the likelihood of unsafe sexual activity and larger numbers of sexual partners. In any emergency involving major social disruption, action must be taken immediately to prevent HIV transmission.

HIV/AIDS is a problem that requires a multi-sectoral approach, particularly in complex emergencies. The UN family looks at war and civil strife as a cause and a consequence of the spread of HIV.

UNICEF is the chief advocate for children, women and families within UNAIDS. Within the broader UNAIDS approach, UNICEF focuses on the following priority programme areas:

- prevention of mother to child transmission;
- young people’s health and development;
- children and families affected by HIV/AIDS;
- AIDS education;
- breaking the silence on HIV/AIDS.

While we should strive to focus on all five of the priority programmes above, at the onset of an emergency it is often only possible to provide partial support.

*Please refer to Annex 9 for further details on the prevention of STDs/HIV/AIDS during emergencies.*

Assure Adequate Supply and Management of Essential Drugs

Millions of people in developing countries are dying needlessly from diseases that could be easily treated with safe, inexpensive drugs. More than one third of the world’s population lacks regular access to essential life-saving drugs. Ensuring the availability of essential drugs for community-level health services is a priority.

Where there are virtually no stocks on hand and the capacity to receive, sort and repack drugs is limited, drugs should be delivered in pre-packed kits ready for immediate distribution to care providers. Quantities in each kit should be appropriate to the size of population served by the average medical team or health post. Policies for dispensing and distributing drugs should take account of established local practices and long-term policies as well as immediate needs. Emergency health kits may be appropriate at the outset, but subsequent supplies of medicines and equipment should be based on specific needs and utilization.

*Please refer to Annex 6 for further details on essential drugs in emergencies.*

Identify and Mobilize Local Personnel

Displaced, refugee and other emergency-affected populations normally include traditional healers, midwives, community health workers and other health personnel. Efforts should be made from the outset to identify and utilize this existing capacity for the management of emergency health activities.

In cases of social upheaval and large population displacements, it may be necessary to recruit additional health workers from within the community and provide them with rapid orientation followed by regular supervision and in-service training. A displaced person with no previous experience can still be a very effective health worker by following basic on-the-spot instructions for a few relevant tasks.

In refugee situations, UNHCR recommends that there be one health worker per 200 families, and that at least 50 per cent of health workers be female in order to ensure health services and information are genuinely accessible to women.
Remuneration of local staff (especially staff hired at the peak of an emergency) should be carefully coordinated among UN agencies and NGOs – to avoid inequalities and large gaps between national salaries and salaries paid to local health workers by international agencies. Salaries should be set according to local standards and be sustainable.

_Please refer to Annex 1, Assuring Basic Health Care Services._

**Re-Establish Basic Health Services**

Interventions to respond immediately at the peak of a crisis should aim at saving lives, but should at the same time re-establish basic health services.

Key priorities include:

- The establishment of a reliable and sustainable cold chain system, medical stores and an effective distribution system for vaccines and essential drugs.
- Orientation and retraining of health staff, followed by the re-institution of regular in-service training covering key maternal and child health issues.
- Consolidation and expansion of initial communicable disease control and reproductive health measures.
- Renewed users participation in health management as part of the rebuilding process.

Where much equipment has been lost, standard sets of the most essential items for each type of health unit should be provided as quickly as possible. The WHO Emergency Health Kit, list C (please see Annex 6), suggests what might be appropriate in order to establish a clinic, including basic laboratory facilities, to serve a community of 10,000 persons. Other standard Supply Division kits may also be appropriate, especially the midwifery, MCH centre and public health nurse kits.

**Assure Health Promotion and Education**

The promotion of healthy practices and positive behaviour through education takes on added urgency in an emergency. Health education efforts in the initial emergency phase should be simple, focused and directly related to immediate public health problems. Other health concerns can be part of broader awareness-raising efforts as the situation evolves. Critical initial messages include:

- proper personal and food hygiene
- safe water and sanitation practices
- measles immunization
- oral rehydration therapy
- recognition and referral of childhood diseases
- STD/HIV/AIDS prevention

Health education strategies will depend on communication channels and culture-specific means with which information is transmitted and received. Those from within the affected community are almost always more effective, especially over outsiders without knowledge of the local culture. It is useful to involve respected local citizens, such as teachers, religious leaders, traditional healers, or traditional birth attendants (TBAs), who can disseminate health messages through their daily contacts with the community. Female communication agents, including community health workers, should be mobilized to ensure women access to basic health information.
Health Assessment and Surveillance

The initial health assessment should be followed as soon as possible with the re-establishment of a basic health information system to provide regular information through both routine monitoring, surveillance procedures and intermittent surveys. The system should serve as a basis for planning, adapting and managing health services during the emergency and long term. It should identify health problems, and in particular potential outbreaks of communicable diseases.

Information should be requested in regular reports from all health posts and medical teams. Information should be segregated only by age (under-fives and over-fives) and gender. In all situations, information from informal sources should be investigated to verify rumours, reassure the population and take action, if needed.

All health workers and medical teams must understand the importance of surveillance and of submitting reports regularly – including zero returns rather than no report. Clear guidelines should be given on how, to whom and when to send their reports.

Please refer to Annex 10 for further information on health monitoring and surveillance in emergencies.

Further Guidance

General


United Nations High Commissioner for Refugees (UNHCR), *Community Services in UNHCR*, UNHCR. Geneva, 1996

Reproductive Health Care


UNHCR, *Field Manual on Reproductive Health In Refugee Situations*, October 1995

World Health Organization (WHO), *The Mother Baby Package*, 1994

Monitoring and Surveillance


Essential Drugs and Supplies


Immunization


WHO, *Safety of injections in immunization services*, WHO recommended policy, (WHO/ EPI/LHIS/96.05), WHO 1996


Diarrhoeal Disease Control


Control of Acute Respiratory Infections

WHO, *Acute Respiratory Infections in Children: Case Management in Small Hospitals in Developing Countries, Programme for the Control of Acute Respiratory Infections*, (WHO/ARI/90.5), 1990

WHO, *Management of the Child with Cough or Difficult Breathing, Diagnostic and Treatment Chart*, (WHO/ARI/94.31), 1994 (available as a pocket–sized version)

Prevention and Treatment of STDs/HIV/AIDS


UNAIDS, *AIDS Epidemic Update*, December 1999
UNHCR, *Reproductive Health in Refugee Situations and Inter−Agency Field Manual*, 1999

**Containing Outbreaks of Cholera, Dysentery or Typhoid**

WHO, *Guidelines for the control of epidemics due to Shigella dysenteriae type 1*, (WHO/ CDR/95.4), 1995
WHO, *Factsheets on environmental sanitation for control of cholera and other epidemic diseases*, 1996

**Other Communicable Diseases**


**Panels**

**Panel 1 – Assessment Checklist**

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<th>ASSESSMENT CHECKLIST</th>
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<tbody>
<tr>
<td><strong>Baseline data</strong></td>
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<tr>
<td>• What specific effects has the situation had on the health of survivors? What casualties?</td>
</tr>
<tr>
<td>• What diseases are normally prevalent in the area? What seasonal variations?</td>
</tr>
<tr>
<td>• In instances of population displacements, were the same diseases prevalent in the areas from which the people have migrated?</td>
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<tr>
<td>• Who is in charge of emergency health/medical services and any special teams?</td>
</tr>
<tr>
<td>• Is capacity sufficient to handle immediate needs? What extra measures are being taken?</td>
</tr>
<tr>
<td>• What evolution can be expected in:</td>
</tr>
<tr>
<td>• The numbers of casualties requiring treatment?</td>
</tr>
<tr>
<td>• The incidence of disease?</td>
</tr>
</tbody>
</table>
• What climatic/seasonal and environmental factors are to be considered?

• How will logistics considerations and constraints influence operations?

• The main health problems and hazards:
  • At present are ________________________________
  • Which can be anticipated are ________________________________

• Priority measures necessary:
  • To prevent further spread of disease are _________________
  • To tackle current health problems are _________________

**Health monitoring**

• What reporting and surveillance systems are operating? What lines of communication between field and central units?

• Do reported mortality and morbidity rates differ significantly from the seasonal norm? (Not simply due to increased medical coverage and reporting.)

**Current epidemiology**

• What special disease control programmes? What coverage? What facilities?

• Is there any evidence of abnormal (for the time of year) prevalence of:
  • Serious dehydration?
  • Frequent diarrhoeas?
  • Measles?
  • Respiratory diseases?
  • Malaria?
  • Neo−natal tetanus?
  • Other communicable diseases?

(Cross−check any reports of epidemics.)

• What are the probable causes? Are people living in unusually crowded/squalid conditions?

**Basic health care services**

• What kind of health services exist? What manner of community involvement?

• What hospitals, dispensaries and other health care facilities exist? Where? What staff?

• What immunization programmes normally operate? What coverage? What staff?

• What effects do cultural/social influences have on the utilization and effectiveness of existing health services?

• How have health services been affected:
  • Premises, equipment?
  • Staff?
  • Supplies?
  • Transport?

• How have pre−existing control programmes been affected?

• To what extent have stockpiles of drugs and essential supplies been affected:
Locally? 
Nationally?

Has local production of drugs and essential supplies been disrupted?

What is the present effectiveness of:

Community-level PHC, MCH and other basic health services?
Referral services?
Immunization programmes? Is there a functioning cold chain?

What actions have already been taken to re-establish services? What constraints remain?

What personnel (qualified, trainees and experienced auxiliaries) are available? Do they have the facilities to live and work effectively? What other personnel might be mobilized?

What quantities of essential supplies – dressings, ORS, basic drugs, vaccines – are available? Where? For how long will stocks last?

What actions/plans have already been taken/prepared (by the government or others) to provide personnel, supplies, and to rehabilitate/reinforce pre-existing services?

To what extent will existing stocks, already-planned inputs and any local production of drugs and other supplies meet expected requirements?

The restoration/provision of basic community-level health care and MCH services requires the immediate provision of __________ (E.g. temporary shelter/repairs for health premises, emergency drugs and other supplies, vehicles, fuel, vehicle repairs, additional personnel).

To then consolidate and re-establish reasonable community-level and essential referral services requires __________ (E.g. reconstruction, re-equipment, resupply, retraining. Specify feasible targets and means for implementation.)

Priorities and practical possibilities for immunization operations are __________ (E.g. measles vaccination of all children, full immunization (EPI) of children, tetanus vaccination of pregnant women. Specify numbers, schedules and include cold chain requirements.)

Overall health management and administration can cope/needs to be reinforced by __________.

Health monitoring

What reporting and surveillance systems are operating? What lines of communication between field and central units?

Do reported mortality and morbidity rates differ significantly from the seasonal norm? (Not simply due to increased medical coverage and reporting.)

The (re)establishment of an effective disease surveillance system requires __________

Recommendation for gathering more information

More detailed, expert investigations/surveys are needed to plan operations for __________ (e.g. reconstruction, re-equipment, retraining).
Chapter 1 – Annex 1: Assuring Basic Health Care Services

Objectives

- To ensure the efficient organization and delivery of essential emergency health care at the community level in the context of sustainable long-term services.

Overall Management

In a major emergency, a full-time Emergency Health Services Coordinator should be designated by the government and provided with appropriate authority and necessary administrative support. When the government is non-existent, the U.N. should take the initiative.

Particular attention should be paid to:

- mobilizing and re-assigning available medical and paramedical personnel, including any outside medical teams, according to priority needs;
- redistributing and ensuring the controlled use of the available stocks of drugs and other medical supplies and ordering and receiving additional supplies, including control and co-ordination of donations;
- establishing budgets for all aspects of health care operations and ensuring the availability of operating funds to all field units;
- systematically collecting and analysing data on the incidence of diseases (epidemiological surveillance) and ensuring prompt and appropriate responses to reports of outbreaks;
- co-ordinating activities with other related operations (i.e. food, water supply, sanitation, education);
- providing precise guidelines to all personnel and teams engaged in health-related activities;
- involving local communities in the management of their health units.

Guidelines should specify: standard treatment schedules to be applied using a limited number of essential drugs; what vaccination activities to undertake and how; how to requisition and take delivery of supplies; and what reports to submit and how. Clear guidelines on the role of local communities in relation to the management of the unit should also be established.

Medical and Paramedical Personnel

Existing trained health service personnel, community health workers and traditional birth attendants (TBAs) should be supported to provide necessary services to their communities. If the emergency situation requires temporary additional arrangements, existing personnel must be fully involved and integrated into the operation.

Special medical teams sent to disaster areas should be small, mobile and adaptable. In only a few instances will highly specialized teams be needed. Experience shows that previous field experience and personal qualities are usually more important than advanced training and knowledge.

Adequate numbers of community health workers are essential to provide primary health care to all communities. Sufficient numbers of paramedical and auxiliary workers are necessary to ensure the efficient use of more highly trained medical personnel. Pharmacists and laboratory technicians are needed to support curative services and the operations of medical teams.
Wherever there are major health problems or large population displacements, new health workers should be recruited from within the community and given rapid initial training followed by regular supervision and in–service training:

- carefully select candidates (from all sections and age groups of the population, if possible) and ensure that they are accepted by the community;
- establish clear policies for the remuneration of workers, in coordination with other Agencies and NGOs (to ensure standardized remuneration rates);
- prepare the training syllabus, methods and materials appropriate to the specific health problems and the background of the trainees;
- give special attention to the selection and training of trainers and involve existing trained nurses and other community workers.

The work and training of community health workers should focus on:

- practical ways of improving hygiene and sanitation in the community, including preventing contamination of water supply, the sanitary disposal of excreta and arrangements for personal and food hygiene;
- identifying malnourished children, arranging their enrolment in special feeding programmes, ensuring their attendance and helping mothers to prepare weaning and supplementary foods;
- immunizing children, including registering children and organizing the community for vaccination sessions;
- promoting home–based oral rehydration therapy for children suffering from diarrhoea and ensuring treatment with ORS for cases of dehydration;
- bringing individuals needing medical attention, including pregnant women, to appropriate clinics and, wherever feasible, ensuring assistance to women at childbirth with postnatal follow–up and referral.

Wherever health infrastructure is not extensive, promote the further training of village–level workers in the diagnosis and management of common disorders (i.e. dehydration, respiratory diseases, malaria, as well as the treatment of minor injuries).

Premises

Where health facilities (such as dispensaries, health centres and hospitals) have been damaged:

- rapid provision of plastic sheeting and tarpaulins, locally available construction materials and/or limited funds should enable initial, temporary repairs to be made so that essential services can continue/resume;
- detailed surveys and the preparation of quantity and cost estimates for any major reconstruction work (including that of training institutions) should be undertaken as soon as possible in order to plan and budget for the rehabilitation phase, only if the health unit fits the new health plan and strategies.

In cases of displaced populations:

- existing facilities in the area may need to be expanded, at least temporarily;
- new clinics may need to be established.

In general, one clinic for every 5,000–10,000 people and one health centre per major population concentration is recommended. (Naturally, local circumstances should be taken into account when calculating such ratios.)
Where no premises exist, the construction of traditional structures that can be erected quickly using locally available materials is recommended. Barring such options, tents can provide an initial temporary alternative. Emergency field hospitals are the least recommended, as they often arrive too late to be used in the initial casualty management phase, contain many items not required for ongoing health care and can be expensive, particularly when transported by air.

**Equipment**

Where much equipment has been lost:

- provide standard sets of the most essential items for each type of unit as quickly as possible, taking into account equipment that medical teams might be bringing with them;
- plan carefully for the rehabilitation phase by noting the necessary re-equipping needs of larger institutions, including training units.

Refer to the WHO Emergency Health Kit List C (please refer also to Annex 6) for suggested provisions required to establish a clinic. Other standard Supply Division kits may also be useful, particularly the midwifery, MCH centre and public health nurse kits. Ensure that provisions are appropriate to the levels of staffing and expertise that is and will, in the long-term, be available at the various centres.

**Vehicles**

Where vehicles essential for mobile outreach health services have been lost or damaged or when such services have to be developed or extended to new areas:

- repair or, when necessary, replace vehicles to enable services to continue or resume;
- ensure necessary supplies of fuel and lubricants;
- ensure arrangements for ongoing maintenance.

**Possible UNICEF Inputs**

Depending on the assessment of actual needs and the complementary capacities of UNICEF and its partners, some of the following UNICEF inputs might be considered:

- funding for additional (preferably national) personnel to be mobilized for central and field level coordination and supervision of emergency health operations;
- funding for the mobilization and operation of specialized national medical teams and for the participation (i.e. funding travel costs) of appropriate personnel from national institutions;
- sets of basic equipment for clinics, dispensaries, MCH centres and hospitals, which may be acquired by the diversion of stocks on hand or en route for regular programmes, local purchases or air deliveries from Supply Division;
- kerosene for basic health units and sterilization equipment;
- plastic sheeting, tarpaulins, large tents, locally available repair materials;
- spare parts/funds for the repair of damaged vehicles and replacement vehicles, where necessary;
- other reconstruction materials, including electric and water fittings;
- consultant missions, when necessary, to assist in the assessment and planning of rehabilitation services in areas of particular concern to UNICEF (e.g. pediatric care, MCH
services, EPI programmes);

- funding for the training of new paramedical and village health workers, including the preparation and production of training materials and guidelines and refresher training for existing health workers;

- materials, equipment and supplies to re-establish long-term training programmes for community health workers, nurses, midwives and paramedical workers.

Only in very exceptional circumstances does UNICEF provide or sponsor new medical teams or individual medical field workers, which are usually provided by other organizations. WHO may advise and assist the relevant authorities in overall management and coordination.

During the initial phase of an emergency, deliveries should be restricted to essential medical items only – namely, items without which the necessary minimum level of service cannot be provided. Additional equipment may be provided at a later date.

UNICEF inputs should normally be focused on the needs of the lower-level health care delivery facilities (dispensaries and health centres). Equipment for hospitals should be reserved for pediatric and maternity wards, as well as outpatient and laboratory services.

Further Guidance


UNHCR, Community Services in UNHCR, Geneva, 1996


WHO, Emergency Health Kit, 1991


Médecins sans Frontières, Essential Drugs, Practical Guidelines, Hatier, Paris, 1993


Chapter 1 – Annex 2: Immunization (Measles and other EPI Antigens)

Objectives

- To protect children against measles and to prevent measles outbreaks. In the event of an outbreak before mass immunization, to reduce the number of cases and mortality rate.

- To protect children against other vaccine-preventable diseases by re-establishing full EPI operations as soon as possible.

- To protect women and their newborns against tetanus.
Priorities and Strategies

Children who are malnourished and living in overcrowded conditions are especially susceptible to vaccine-preventable diseases. During an emergency, especially if population displacement occurs, existing EPI operations may become disrupted, leaving the youngest and most vulnerable children unprotected. In addition, emergencies have a disproportionate effect on disadvantaged population groups, whose pre-emergency vaccination rates are often below the national average.

In emergency situations, priority must be given to preventing measles outbreaks and efforts must be made to immunize all young children as completely and as quickly as possible.

A specific immunization strategy should be established and agreed to by the Ministry of Health and by all concerned organizations. Such a strategy should be based on local epidemiological risk assessment within the following general framework.

Where there has been widespread social disruption and large numbers of people are displaced or living in crowded conditions, especially if malnutrition is widespread:

- absolute priority must be given to immunizing children against measles as quickly as possible through a carefully-managed emergency vaccination campaign;
- full EPI operations should be re-established in line with national protocols as quickly as possible thereafter, as the situation evolves;
- immunizing women of childbearing age against tetanus should also be a high priority in such conditions, especially when sanitary conditions are poor, when neonatal tetanus was common before the emergency and when the majority of deliveries are without trained support.

Where access to specific population groups is difficult, and particularly where continued access is uncertain:

- Oral polio vaccine (OPV) and other EPI antigens may be included in the context of an emergency measles campaign, provided sufficient capacity and resources are available and the measles vaccination would not be delayed;
- according to the epidemiological risk, other antigens like yellow fever and meningitis should be considered. Immunization against diphtheria will be a priority in countries where this disease represents a major public health problem.

Where there is no immediate risk of a measles outbreak and normal structure services remain intact and functional:

- ensure the continued functioning of the national immunization service with special attention to maximizing coverage among the worst-affected population groups.

In all cases:

- The integrity of the cold chain must be assured as well as the careful, systematic planning and supervision of all operations.
- Families must be informed and communities must be mobilized in support of all immunization activities.
- The capacity of the national EPI structure should be reinforced and used wherever feasible. Immunizations should be conducted within the framework of established national protocols unless concerned competent authorities determine otherwise and agree on specific changes.
- Where special teams have to be mobilized to serve refugees and displaced populations, the teams should extend their operations to the host community in the same area. This will reduce the tensions that are inevitably created when refugees are perceived to be receiving services that are not available to the local host population.
Special vaccination campaigns may also be required to contain outbreaks of meningitis or yellow fever in parts of Africa or Japanese encephalitis in parts of Asia. In case of an outbreak of one of these diseases, top priority may need to be given, temporarily, to administering the relevant vaccine to high-risk population groups.

**Emergency Measles Vaccination Activities**

Measles accounts for about 900,000 deaths a year (WHO, 1999. Report on Infectious Diseases. Removing Obstacles to Health Development). Measles is common and especially dangerous in emergencies, when populations are displaced or live in overcrowded conditions, sanitation and shelter are poor and food and safe water are in short supply. In such situations, which are particularly common among displaced populations and in areas of recurrent conflict, measles can spread rapidly and can result in high mortality rates. Malnourished children are at especially high risk of complications and death following an acute attack of measles. Measles can trigger acute PEM (kwashiorkor) and worsen vitamin A deficiency in children whose nutritional status is borderline.

**Prompt measles vaccination of children is possibly the most important and urgent public health intervention for any displaced population**

For the displaced as well as for populations living in high density localities affected by food shortages and malnutrition, a measles campaign should be organized regardless of previous vaccination rates reported. If there is known low vaccination coverage, it becomes more important to set up a measles campaign immediately. Vitamin A should be administered at the same time as the measles vaccine.

Where displaced persons are living among the local population rather than separately in camps, children in the host population should be vaccinated simultaneously.

In particular circumstances, consideration may be given to administering other antigens at the same time, provided this would not delay the measles vaccination.

**Vaccinate children from 6 months of age**

In normal times – under regular vaccination schedules – measles vaccine is administered to children at 9–11 months of age in developing countries. Where conditions are such as to demand an emergency measles campaign, the lower age limit should be reduced to 6 months of age. A child who receives the first dose before 9 months of age should receive another dose as soon as possible after reaching 9 months.

The upper age limit must be determined in each situation in light of the epidemiology of measles in the population. In general, there is no need to vaccinate children of 5 years of age and above if the population comes from an area where there has been high known measles transmission or previous high coverage.

The risk of a child dying from measles diminishes with age, but transmission can occur from older to younger children. Thus, older children who are thought to be under-immunized should be regarded as a potential threat for a measles outbreak and should be included in the target group for vaccination. This may be the case with a displaced population drawn from isolated communities normally dispersed over a wide area and where there has been little measles transmission in recent years.

Discuss and agree on a strategy with the Ministry of Health based on the best possible technical advice. Check local epidemiological expertise and obtain advice from UNICEF headquarters or directly from WHO–EPI, whenever possible.
Vaccinate all children in the chosen age range, with priority to the youngest

All children in the chosen age range must be vaccinated as soon as possible. High coverage – close to 100% – is necessary to prevent an outbreak, with priority given to the 6–59 month age group and especially children in the first year of life (i.e. 6–11 months). There are no risks associated with re-vaccination. Malnutrition, diarrhoea and minor illnesses are not contraindications to vaccination. During emergencies, there are no contraindications to measles vaccination.

Measles vaccine and vitamin A

WHO suggests giving vitamin A supplements to all children as they are vaccinated. Record the administration of vitamin A in order to avoid the risk of over-dosage: this can most conveniently be done on the vaccination card itself. In a prolonged emergency, supplements may need to be provided on a continuing basis every 4–6 months in order to protect children against vitamin A deficiency.

Consider inclusion of other antigens

Wherever there is risk of a measles outbreak sufficient to justify an emergency vaccination campaign, administration of the measles vaccine is the overriding priority and must not be delayed. The inclusion of other antigens should only be considered if it will not detract in any way from the progress of the measles vaccination.

However, the opportunity to provide protection against other epidemiologically important diseases should not be missed in situations where:

• access is difficult and
• coverage by regular EPI operations is unlikely in the near future, but
• capacity and resources are available to administer additional antigens during the emergency campaign without detriment to the measles vaccination.

The Oral Polio Vaccine (OPV) requires little in terms of additional capacity. In countries not officially declared ‘polio-free’, OPV may be given at the same time as the measles vaccine to all children 2 months through 5 years of age.

DPT and yellow fever vaccine should normally be administered as part of an emergency campaign only if there is currently an outbreak in the area. DPT can be given at the same session as measles (using separate syringes for measles and DPT).

In exceptional situations, consideration may be given to administering tetanus toxoid (TT or Td) to women 15–49 years old during the visits of emergency vaccination teams to particularly inaccessible areas.

Careful professional judgement is required to determine the best course of action in each situation, taking into account operational and logistic factors as well as epidemiological risk.

Re-Establishing Regular EPI Activities

A full EPI programme should be re-established as quickly as feasible, in line with established national EPI policies and procedures. This will normally include the six antigens for children, and tetanus for women, as indicated in Panel 2.

In some countries, yellow fever and hepatitis B may also be included. Immunization should be an integral part of a larger package of health care services.

Where the programme follows an emergency campaign, it must seek to complete the vaccinations for all children under 5 years of age who were covered in that campaign, while providing the full EPI schedule for newborn infants and others who were not covered in the campaign (notably new arrivals among the
It is essential that the national EPI authorities be fully associated with and take as much responsibility as possible for the ongoing EPI programme.

Where daily vaccinations through first−level community health facilities cannot be assured, due to inadequate human resources or cold−chain facilities, outreach teams may visit communities on a regular cycle − not less than once every four weeks.

**Preventing Neonatal Tetanus: Administration of TT (or Td) to Women**

Neonatal tetanus is a risk in most emergency situations in developing countries, especially in areas where it was a common problem before the emergency and where conditions of hygiene and general sanitation are poor and many deliveries take place without medical or midwifery support. In such situations, the administration of tetanus toxoid to all women of childbearing age is advisable. Health workers and health promotion activities should encourage women to seek such vaccination. TT is used in most countries; Td (tetanus toxoid combined with diphtheria vaccine) is used in countries where there is risk of epidemic diphtheria.

Normally anti−tetanus vaccination should be offered to pregnant women through prenatal services, in accordance with national policy. However, in circumstances where an emergency measles campaign is required for children and sufficient capacity exists, it may be appropriate to administer TT (or Td) vaccine at the same time to women and adolescent girls. This should be considered only if completion of the measles campaign would not be delayed.

Vaccination should be offered to women who do not have vaccination records showing that five valid doses have already been received or that the minimum interval since the last dose has not yet passed. Priority should be given to pregnant women but, if resources permit, all women of childbearing age (15−49 years) should be included.

Every effort should be made to ensure that previously unvaccinated women receive a second dose of TT or Td four weeks after the first dose and a third dose after a further 6 months, especially in crowded camp conditions. (WHO recommends fourth and fifth doses 1 and 2 years later in order to achieve lifelong immunity: these should be provided through regular MCH services, when feasible.) All vaccinations should be recorded.

**Organizing and Implementing Emergency Immunization Field Operations**

The WHO/EPI training guidelines provide detailed instructions on organizing immunization programmes under normal conditions. Many of the same principles apply, but some adaptation to local conditions will usually be needed in an emergency. Essential steps in organizing and implementing emergency immunization field operations are as follows.

**Specify the target population(s) and priorities**

Specify, on the basis of local epidemiology, the age range of children to be vaccinated against measles. Estimate the number of children in the target group in each distinct geographic area. If reliable demographic data are not available when operations are being planned, take the best available estimates of the total population to be served in each area. Use data and know−how from the Country Office whenever possible.

Make allowance for any continuing or expected population movements and estimate the numbers of children based on the following typical breakdowns:

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Normal population</th>
<th>Refugees</th>
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<tbody>
<tr>
<td>Children 6–59 months of age</td>
<td>16%</td>
<td>20%</td>
</tr>
<tr>
<td>Children 5–14 years of age</td>
<td>35%</td>
<td>45%</td>
</tr>
</tbody>
</table>
Define specific objectives for the emergency campaign, the strategies to achieve those objectives, and how regular EPI operations will be re-established. This includes deciding, in the case of areas where access is difficult, whether the campaign is to be restricted to measles or whether other antigens can and should also be administered at the same time.

Strategies will depend largely on the circumstances of the target population (either in camps, urban areas or dispersed) and the human and other resources available. For example, the objective and strategy could be defined as follows: 90% of under-12 children to be vaccinated against measles and simultaneously provided with vitamin A supplements through use of existing health facilities and mobile outreach teams.

**Draw up an operational plan and specify resource requirements**

Calculate requirements for vaccines, vaccination supplies, cold-chain elements (based on the number of teams and on geographic and logistic considerations), vaccination cards and tally sheets, and vitamin A. Specify required delivery schedules to replenish and complement in-country stocks.

Draw up a specific (provisional) plan and schedule for field operations. This may need to be adjusted as field operations evolve, but it is essential to have a clear framework within which to start operations. The follow-up phase of re-establishing regular EPI activities based on the general practices of the national EPI programme should be envisaged from the outset. Vaccination cards should be updated and issued for each vaccinated child.

Prepare a budget showing the requirements for the campaign as a whole, and list the contributions to be provided by all parties involved. Break it down into discrete operational phases, as appropriate and possible. Panel 3 suggests the various line items that may need to be included in the budget.

Specify the fixed locations and/or number and composition of mobile teams to be used, the organizations to provide the human resources and recruit local personnel and the transport to be used. Specify responsibilities for supervision, including assuring transport for supervisors. All the above must be done in close collaboration with the responsible national authorities and NGOs.

**Mobilize resources and ensure systems for efficient management of supplies**

Some quantities of vaccines and vaccination supplies, as well as cold-chain elements, transport and human resources will already be available in-country in most situations. These will normally be used or borrowed to initiate any emergency vaccination campaign. Additional resources will be mobilized from external sources to complement what is already available.

In collaboration with the national EPI authorities and other health agencies (NGOs), rapidly establish an inventory of available resources in terms of:

- vaccines
- vaccination supplies
- cold chain
- vaccination cards and tally sheets
- vitamin A
- personnel for field teams and supervision
- transport and fuel
- materials and other resources for social mobilization
- funds for operational costs

Various agencies are likely to be planning to bring in additional resources. Take account only of those that are absolutely guaranteed with a firm arrival date in the very near future.

Ensure the prompt ordering of all supplies required. Provide all necessary specifications: mistakes in ordering or delays in deliveries can sabotage an emergency vaccination campaign. Check regularly on the status of orders and expected delivery dates.
Efficient management of supplies is crucial, both to avoid losses and to ensure that the right quantities are in the right place at the right time and in good condition. A simple system of documents − ledgers, stock cards, waybills and monthly stock reports − is perfectly adequate. Signed records of all transfers (receipts and dispatches) and the close supervision of all stocks and records are essential.

**Human resources**

Priority should be given to mobilizing available local personnel with experience. Many refugee and displaced populations include most or all of the people required to run a vaccination campaign. In complex emergencies where previous services have been totally disrupted, personnel who operated those services might still be present among the population, both basic−level staff (vaccinators, social mobilizers, cold−chain staff) and management staff (field supervisors and managers).

After verifying their documents, operational agencies, or in exceptional cases UNICEF itself, may employ such persons at a daily rate in line with those prevailing for similar jobs in other programmes. Encourage all concerned agencies to coordinate employment policies and harmonize rates of remuneration. Where documents have been lost, simple tests or questions about EPI policy and practices enable an immunization programme manager to screen job applicants, who will usually be more numerous than available positions.

Any requirement for international expertise for overall planning and management may be met by a combination of secondment of EPI staff from other UNICEF offices and the mobilization of expertise from specialist international institutions.

**Cards and tally sheets**

Use existing vaccination cards, where available, provided they are uncomplicated. If cards are too complex, staff will spend too much time filling them out, creating queues of impatient mothers. When necessary, design and print simple cards locally to record the name and age of the child, the date of the vaccination and the name(s) of the vaccine(s) given. The administration of vitamin A should also be recorded – on the back of existing cards, if necessary.

If local printing is not immediately available, cards can be run off on photocopy machines, 12 to a page, as a temporary measure. In a conflict situation, it may be appropriate to omit reference to any particular national authority so that the cards may be used among all population groups without objection from any factions.

Combined vaccination cards and growth charts are useful when full MCH services are available or are expected to be reinstated with wide coverage in the near future. Otherwise, they are not necessary for an emergency campaign.

Tally sheets should record only the number of children and mothers vaccinated, by antigen and age group, using tally strokes. Registers are unnecessary and ill−suited to an emergency campaign.

**Ensure necessary transport**

If there are many separate locations to be served, a sufficient number of vehicles must be dedicated to the operation for the duration of the emergency vaccination campaign. NGO partners may be able to provide some vehicles, but dedication is often difficult due to the inevitable competition among different programmes for scarce transport. In many situations, the most satisfactory approach will be to rent vehicles specifically for the emergency vaccination campaign from local sources.

The most flexible vehicle for outreach vaccinations is a pickup, as it can carry supplies, equipment or vaccinators in the back. Avoid passenger cars, which are more expensive and less flexible.
Ensure close supervision of the storage, transportation and handling of vaccines

Ensure close supervision of the storage, transportation and handling of vaccines throughout the delivery (cold) chain and during field vaccination sessions. This includes ensuring the correct use of the vaccine, cold chain, and monitoring sheets (vaccine vial monitors – VVMs), which are packed with all shipments of measles, polio, DPT and BCG vaccines supplied by UNICEF and WHO.

All vaccines must be kept cool and shaded from sunlight at all times. Field teams must:

• always keep cold boxes and vaccines carriers in the shade;

• open cold boxes and vaccine carriers only at the last minute when vaccines are to be given, and check the temperature on opening each cold box – also check the VVMs, when available;

• keep prepared vaccines shaded during sessions: metal foil can be very useful for this; and

• destroy all partially–used vials of measles, BCG and yellow fever vaccines at the end of each outreach vaccination session. (See Panel 5, concerning the conditions under which opened vials of OPV, DPT, TD, DT, TT and hepatitis B vaccine may be kept.)

Ensure that, during transport and vaccinations sessions, vials of DPT and TT (or DT, Td) vaccine are not in direct contact with a frozen ice pack. Vials of these vaccines should be wrapped in newspaper before being placed in vaccine carriers to avoid freezing, which destroys the potency of the vaccine.

Inform and mobilize the population

The understanding, support and participation of community leaders and of the population as a whole is essential. Information and social mobilization using all available means of communication (radio, posters and meetings) and organizational structures – government bodies, NGOs and community–based organizations – is critical. This is of course more difficult during an emergency when social services and infrastructure may be disrupted, but the target population might be more easily accessible when in a densely populated area or a camp.

Implement the campaign

Focus initially on the most densely–populated localities which can be readily supervised. The experience gained will be invaluable and help you avoid problems when moving operations into more difficult and demanding areas. Give priority to any areas in which measles has already been detected: this will reduce the possibility (or at least the rapidity) of the disease spreading to other areas.

In a camp situation, vaccination may be arranged when families are registered, if this is done within a few days of arrival. In such cases, a vaccination team must be placed next to the registration desk/table at each registration point or centre and arrangements ensure that every family is automatically channelled from one to the other by corrals or other mechanisms to control the flow of people presenting themselves for registration. This can be an efficient way of protecting children among new arrivals when prompt registration is assured.

Promptly investigate any reports of vaccination–related deaths

Some children have died shortly after being vaccinated, resulting in considerable and understandable anxiety among the population and health personnel and in the suspension of vaccination activities. Such deaths may not in fact be related to the vaccination at all and, where there is a connection, they are usually due to contamination of vials rather than problems with the vaccine itself. However, each report of a vaccination–related death must be taken seriously and investigated immediately in order to identify the cause of death and avoid the vaccination programme being unduly disrupted. Ensure that the investigation is undertaken expeditiously. Notify Supply Division immediately and send samples of the vaccine for testing at a suitable international laboratory as advised by Supply Division or WHO. (Samples must be kept cool during
Establish reliable information, reporting and consultation mechanisms

Reliable information systems, reporting and consultation mechanisms are essential to enable programme supervisors and managers to monitor the situation and adapt implementation plans as new information becomes available and the situation evolves. Rely also on information and data from the Country Office.

- The systematic gathering, collation, analysis and cross-checking of information from all available sources is essential. This includes information on the overall situation and on particular population groups.

- Regular and frequent meetings within each operational area of team leaders with the area supervisor are an excellent mechanism to discuss experiences, resolve problems and decide, when appropriate, to re-deploy resources, to curtail or extend planned vaccinations at particular sites or to add new sites, in response to changing conditions.

Be sure that all children at a given site have been vaccinated before closing operations there. Once the initial demand for vaccinations has been met, vaccinators may go from house-to-house/tent-to-tent to check vaccination cards, giving particular attention to households most distant from the vaccination site.

Monitor progress and, when appropriate, evaluate coverage

During the acute phase of an emergency, effort and resources must be focused on finding children who have not been vaccinated and vaccinating them. Data from all areas on new cases of measles must be closely and continuously monitored through the health monitoring and information system. Once the situation has stabilized, surveys may be undertaken to determine actual coverage.

Where reasonable estimates to the total population are available, rough estimates of coverage may be made by dividing the number of doses administered in each area by the estimated target population in that area. In practice, however, in many situations total population estimates are extremely unreliable and data for the numbers of children vaccinated are used to cross-check the plausibility of the figures for total population.

Where a campaign has to cover a very large area and, therefore, is implemented in phases over an extended period, coverage surveys may be undertaken at intervals during the campaign and towards the end of it. The results, together with measles case data, will indicate the extent to which the campaign has achieved its objectives. Evaluations during the campaign will enable mid-course corrections to be made, where needed, by exposing weak points in what might have been thought to be a successful operation.

In all cases, ensure that the capacity exists and arrangements are made to analyze the data promptly.

Coverage should be evaluated using cluster surveys. Use the 30 Cluster Survey Assessment Software (COSAS, which is available free-of-charge from WHO) to analyze the data. Involve all concerned parties in the evaluation exercise. Apply the WHO cluster selection procedure to the best available data, randomly allocating clusters within neighbourhoods or other geographical subdivisions when fewer than 30 subdivisions are available within a given area.

Data on nutritional status and other key indicators of child health and well-being can, in principle, be gathered at the same time but this will require more time both to train the survey field workers and to gather the data at each site. The analysis will also be more complicated. Experience has repeatedly demonstrated the importance of keeping any survey activity as simple as possible.

Data on new cases of measles should be broken down by age and immunization status, wherever possible, in order to determine whether the disease is largely restricted to children under 5 years of age or also affects older children.
Vaccination Supplies and Equipment

Vaccines

Normally, it is possible to initiate emergency vaccination operations by borrowing supplies from the national programme. Requirements for additional deliveries (by air) should be planned to replenish stocks and to cover any increased level of demand.

When ordering vaccines:

- specify whether diluent is required or not;
- specify required delivery dates – the need for replenishment of in–country stocks may not be immediate; and
- make an appropriate allowance for wastage based on local experience and/or the indications given in Panel 3.

For large sessions, order vaccines in 20–dose vials (to reduce costs) rather than the usual 10–dose vials.

Cold Chain

Keeping vaccines cold from delivery at the airport to use in a field vaccination session requires:

- cold room and freezers at airport and in the capital;
- refrigerators at regional and area level;
- cold boxes for transfers between locations; and
- small vaccine carriers for field operations.

Panels 4 and 5 provide additional details.

Vaccination Supplies

For an emergency vaccination campaign, autodestruct syringes are recommended for administering measles and DPT vaccines and tetanus toxoid, even if the regular national EPI programme uses disposable or sterilized syringes.

Separate, flat–packed incinerator cartons must be ordered and distributed with the syringes. Vaccinators must be trained and supervised to ensure that used syringes are placed and finally burned in the incinerator carton.

Where disposable syringes and needles are used (at least for BCG), great care must be taken to ensure that they are used only once and immediately destroyed by burning. Incinerator cartons should be ordered and distributed with the needles.

Autodestruct syringes remain the means of choice for administering injectable vaccines (excluding BCG) even when very large groups are involved.

When a normal EPI operation is re–established, supplies should be ordered in line with the specifications of the national programme.

Possible UNICEF Inputs

Immunization is part of UNICEF Core Corporate Commitments. Depending on the assessment of actual needs and possibilities, some of the following inputs might be considered:
• Vaccines – against a carefully planned delivery schedule

• Cold chain components: refrigerators, cold boxes, vaccine carriers, ice packs, thermometers, spare parts for refrigerators, possibly stand–by generators

• Self–disabling syringes

• Vitamin A supplements

• Programme planning and management expertise

• Training

• Social mobilization expertise

• Transport (rental and/or purchase)

• Local operating costs (including kerosene for refrigerators)

Further Guidance


WHO, *Reducing the risk of unsafe injections in immunization programmes*, (WHO/EPI/LHIS/94.02), 1994


WHO, *Safety of Injections in Immunization Services, WHO recommended policy*, (WHO/EPI/LJIS/96.05), 1996


Panels

Panel 1 – Key Principles of an Emergency Vaccination Campaign

<table>
<thead>
<tr>
<th>KEY PRINCIPLES OF AN EMERGENCY VACCINATION CAMPAIGN</th>
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<tbody>
<tr>
<td>• Careful planning and organization ensures that vaccines, vaccination teams and supplies and the target children are brought together at the right place and at the same time.</td>
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<tr>
<td>• The storage conditions and expiry dates of all vaccine stocks are closely monitored.</td>
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<td>• Field teams are adequately trained and supervised and exercise care in handling vaccines to ensure that they retain their potency.</td>
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</table>
• National personnel administer the vaccines.

• Vaccinations are recorded on cards issued to each child. Cards also record vitamin A administration. (In long–term programmes, they may be combined with a growth chart.)

• A follow–up EPI programme compatible with the regular national programme is envisaged from the outset.

• The campaign is planned by or in close consultation with the national EPI authorities.

Panel 2 – Outline Budget for an Emergency Vaccination Campaign

<table>
<thead>
<tr>
<th>OUTLINE BUDGET FOR AN EMERGENCY VACCINATION CAMPAIGN</th>
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<tbody>
<tr>
<td>Supplies and equipment</td>
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</tr>
<tr>
<td>• vaccines</td>
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<td>• vitamin A</td>
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<tr>
<td>• additional cold–chain items</td>
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<tr>
<td>• vaccination supplies:</td>
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<tr>
<td>• injection equipment</td>
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<tr>
<td>• sterilization equipment (if needed)</td>
</tr>
<tr>
<td>• printing/production of vaccination cards, forms, etc.</td>
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<tr>
<td>• communication/social mobilization materials and equipment.</td>
</tr>
</tbody>
</table>

Cash for operating costs

- salaries and DSA for international staff and consultants
- cost of temporary staff
- vehicle rentals, fuel, drivers
- rental of additional storage, premises
- training
- surveys
- social mobilization activities
- reception, clearance and transport of vaccines and supplies

Panel 3 – Cold Storage Space Needed by Vaccines

<table>
<thead>
<tr>
<th>COLD STORAGE SPACE NEEDED BY VACCINES</th>
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<tbody>
<tr>
<td>Vaccine</td>
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<tr>
<td>---</td>
</tr>
<tr>
<td>Measles</td>
</tr>
<tr>
<td>Polio</td>
</tr>
<tr>
<td>DPT</td>
</tr>
<tr>
<td>BCG</td>
</tr>
<tr>
<td>Tetanus</td>
</tr>
</tbody>
</table>

Notes:
1. Yellow fever and hepatitis B require the same space as measles.
2. The figures shown include space for the packaging and the diluent necessary for the respective vaccines, and assume vaccine in 20–dose vials. The figures for 10 dose vials are similar. Hepatitis B in small, 2–dose vials, requires double the volume.

Panel 4 – Choosing Cold Chain Equipment

### CHOOSING COLD CHAIN EQUIPMENT

Aspects to be considered for cold boxes and vaccine carriers:

<table>
<thead>
<tr>
<th>Volume Capacity: How much vaccine will be carried?</th>
<th>Weight: How will the box be carried?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cold life (quality of insulation):</strong> How long will the vaccine be in transit and in what ambient temperatures?</td>
<td><strong>Durability:</strong> What conditions will the box be exposed to?</td>
</tr>
<tr>
<td><strong>Price:</strong> Which box meets the above needs for lowest price?</td>
<td></td>
</tr>
</tbody>
</table>

Aspects to be considered for refrigerators and freezers:

<table>
<thead>
<tr>
<th>Power source: What reliable sources are available: electricity (voltage, frequency); bottled gas (type); kerosene; solar?</th>
<th><strong>Cold life:</strong> For how many hours may contents need to be kept below 8° C in case of power source failure?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Volume Capacity:</strong> How much vaccine must be stored (a) at 4° C and (b) at −20° C?</td>
<td><strong>Reliability:</strong> What facilities and parts are available locally for different types of equipment?</td>
</tr>
<tr>
<td><strong>Icemaking performance:</strong> How much ice (how many icepacks) must be frozen every 24 hours?</td>
<td><strong>Price:</strong> What model meets the above requirements for the lowest cost?</td>
</tr>
<tr>
<td><strong>Refrigerator performance:</strong> What are local temperatures, day and night?</td>
<td></td>
</tr>
</tbody>
</table>

See the latest edition of the WHO/UNICEF Product Information Sheets for technical details of available equipment. Note that the length of time for which the vaccines will be kept cold without power (“cold life”) varies enormously between different items.

Panel 5 – Dosing And Storage of Vaccines

### DOSING AND STORAGE OF VACCINES

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Dose&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Number and timing of doses</th>
<th>Diluent</th>
<th>Storage&lt;sup&gt;b&lt;/sup&gt;</th>
<th>When ready for use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>0.5ml (10,50)</td>
<td>1 dose at 6 months, a second as soon as possible after 9 months (1 dose only if child already 9+ months)</td>
<td>Special diluent. Must be cool.</td>
<td>2 years at 0° C to 8° C</td>
<td>Destroyed by sunlight. Must be kept below 8° C. Remains potent for 8 hours after mixing, a full session if kept cold and well shaded.</td>
</tr>
<tr>
<td>OVP (Oral polio)</td>
<td>2 or 3 drops, depending on manufacturer&lt;sup&gt;c&lt;/sup&gt; (10,20)</td>
<td>3 doses with minimum 4–week intervals starting at 6 weeks. 1 extra dose at birth, if feasible, especially in polio endemic areas.</td>
<td>None. (Dropper needed)</td>
<td>6–12 months at 0° C to +8° C 1–2 years at minus 20° C</td>
<td>Keep cool and shaded.</td>
</tr>
<tr>
<td>DPT</td>
<td>0.5ml (10,20)</td>
<td>3 doses at minimum 4–week intervals starting at not less than 6 weeks.</td>
<td>None.</td>
<td>18–24 months at 0° C to +8° C. Do not freeze.</td>
<td>Keep cool and shaded.</td>
</tr>
<tr>
<td>BCG</td>
<td>0.05/0.1ml (20,50)</td>
<td>½ dose (0.05ml) for infants 0–11 months. 1 dose</td>
<td>Normal saline.</td>
<td>12 months at 0° C to +8° C</td>
<td>Destroyed by sunlight. Must be stored below</td>
</tr>
</tbody>
</table>
Chapter 1 – Annex 3: Diarrhoeal Disease Control

Objective

To reduce morbidity and prevent mortality in children due to diarrhoeal disease.

Diarrhoeal Disease: A Major Cause of Preventable Deaths

Diarrhoeal disease, acting in concert with malnutrition, is among the principal causes of child sickness and death in emergency situations. Diarrhoeal disease claims nearly 2 million lives a year among children under five. It poses a particular threat in situations when people have been displaced and are living in crowded and unsanitary conditions and when water and food supplies have been disrupted.

Diarrhoea is caused by various types of bacteria and enteric viruses. Malnourished children are more vulnerable to the effects of these pathogens and the diarrhoea they cause, can itself lead to, or aggravate, malnutrition. In severe cases, the immune system is impaired, increasing susceptibility to other infections. A vicious cycle of diarrhoea, malnutrition and disease can set in, frequently ending in death, if not properly treated.

Priorities and Strategies

Strategies to reduce morbidity and prevent diarrhoea–related mortality focus on preventing infection and assuring effective case management to prevent and treat dehydration. Monitoring the incidence and patterns of diarrhoea is necessary to plan and adjust control measures.

Prevention

- Educate parents and the community on the causes of diarrhoea and promote breastfeeding, measles vaccination and personal (especially hand washing), domestic and food hygiene through social mobilization and distribution of information.
• Ensure adequate water supply and environmental sanitation.

Case Management

• Educate parents to give increased fluids and to continue feeding (including breastfeeding) children with diarrhoea, to recognize the signs of serious illness and to seek help if they appear or if diarrhoea continues.

• Ensure correct case management at first−level health facilities and through community−based practitioners by:

  • training all levels of health care workers in oral rehydration therapy techniques and training them to recognize dysentery and cholera, where these conditions could be present;
  • ensuring the availability and regular supply of oral rehydration salts (ORS); and
  • training health care workers in the treatment of moderate and severe dehydration and ensuring the availability of the necessary supplies at designated centres.

• Ensure appropriate use of antimicrobials for cholera and dysentery.

• Ensure appropriate feeding during diarrhoea, including persistent diarrhoea.

Monitoring Prevalence

• Monitoring clinic data and other reports from health workers to detect any change in the epidemiology of diarrhoea.

Case Management: Treating Diarrhoea

The treatment depends on the degree of dehydration and consists in preventing or treating dehydration as appropriate. Anti−diarrhoeal drugs are inappropriate and should never be used. Antibiotics should be used only in cases of bloody diarrhoea and suspected cholera; antiparasitic drugs should be used only for amoebiasis and giardiasis.

In general, it is appropriate to promote the use of home fluids to prevent dehydration by parents and to provide ORS for use by trained community health workers and in health centres and hospitals to rehydrate already dehydrated patients.

Health workers should be trained to assess and treat a child with diarrhoea on the basis of the standard protocols such as the WHO Chart Management of the patient with diarrhoea. Some key elements are summarized below.

Diarrhoea with No Signs of Dehydration

Whenever a child gets diarrhoea, the parents or other caregivers should:

  • give the child more fluids than usual to prevent dehydration;
  • feed the child frequently to prevent undernutrition; and
  • take the child to a health worker if he or she develops signs of serious illness or is not getting better.

The parent or caregiver should continue the extra fluids and feeding until the diarrhoea stops. They should take the child to a health worker if the child does not get better within three days or develops any of the
following: many watery stools, repeated vomiting, marked thirst, eating or drinking poorly, fever, blood in the stool.

**Fluids:** Home fluids should be used, such as cereal–based gruels, vegetable soups, rice water, yoghurt drinks or carefully prepared sugar–salt solutions (if sugar is available). If nothing else is available, plain water should be provided. For a child <6 months old who is taking only breastmilk, only ORS solution or plain water in addition to breastmilk should be provided. The child should be given as much fluid as she/he will take, using the following as a guide:

- child under 2 years old: 50–100 ml (a large cup) given using a spoon (one teaspoonful every 1–2 minutes) after each stool (e.g. 500 ml/day);
- child 2–9 years old: 100–200 ml (large cup) given in frequent sips from a cup after each stool (e.g. 1,000 ml/day);
- 10 years old and over: as much as wanted (e.g. 2,000 ml/day).

If the child vomits, the caregiver should wait 10 minutes and then give the fluid more slowly.

Health workers may give ORS to parents for use at home if it is the national policy to do so and stocks are plentiful. Parents must be shown how to mix the ORS. A two–day supply may be given initially and parents told to continue using home fluids or to return for more ORS, if required. However, in most emergency situations, it is more appropriate – and may be necessary – to reserve available stocks of ORS for use in supervised therapy in health facilities and any special emergency treatment centres.

**Feeding:** If an infant is being breastfed, the mother should continue to do so and increase the frequency of breastfeeding. If an infant is not being breastfed, feeding practices should be reviewed by a competent health worker.

For a child >6 months or already taking solid food, the caregiver should:

- give freshly cooked foods – mashed or ground – consisting of cereal (or another starchy food) mixed, if possible, with pulses, vegetables, meat or fish, adding 1–2 teaspoonfuls of vegetable oil to each serving;
- give fresh fruit juice or mashed banana, if possible, to provide potassium;
- offer food every 3–4 hours (at least 6 times a day) and more often for young children and encourage the child to eat as much as he/she wants. The caregiver should continue giving an extra meal (similar food) each day for 1–2 weeks after the diarrhoea stops.

Similar care should be provided in the household for children discharged from supervised rehydration therapy. Parents may be given packets of ORS to continue the treatment. To the extent possible, health workers should check children being treated at home daily.

**Treatment of dehydration (supervised rehydration):** If a child becomes dehydrated, adequate rehydration can prevent death. The child must be assessed by an appropriately trained health worker to determine the degree of dehydration and the appropriate method of rehydration:

- in the vast majority of cases, oral rehydration using ORS dissolved in clean water is possible and sufficient;
- in only a very small proportion of cases (typically less than 5 per cent), the administration of intravenous (IV) fluids is necessary and is the surest treatment.

The above applies to all forms of acute diarrhoea, including cholera. Prevention is the key and the provision and administration of IV fluids costs more than 50 times as much as treatment with ORS.

Where there is widespread acute diarrhoea, an oral rehydration therapy (or ‘ORT’) section or corner should be established in each health facility with staff trained in the management of dehydration. In case of an epidemic, special emergency treatment centres may be necessary (Please see Annex 1).
Oral rehydration (non−severe dehydration): Solutions must be prepared fresh each day using ORS packets or taken from bulk ingredients and must be administered using a cup, or cup and spoon. This ORS could contain glucose or rice powder with electrolytes. Wherever possible, mothers should remain with the child and be shown how to give the solution. Breastfeeding should continue for infants. For infants under six months who are not breastfed, 100−200 ml of clean water should be given along with ORS during the first four hours. If the child is vomiting, ORS should still be given slowly either in sips by cup and spoon or by nasogastric tube. The child will normally retain more fluid than is vomited out.

The condition of the child must be reassessed every four hours to determine whether (1) to discharge the child for continued treatment at home, if there is no remaining sign of dehydration, (2) to continue the present treatment or (3) to switch to IV fluids, if the condition becomes severe.

Droppers may be used to introduce solution into the mouths of very small babies. If an infant is habituated to bottle feeding and rejects a spoon, it may be necessary to give the ORS solution using a feeding bottle initially – to save the child’s life without resorting to IV fluids or a nasogastric tube. (The mother should be trained in how to replace the bottle at a later date.)

Intravenous (IV) fluid administration (severe dehydration): If a child shows signs of severe dehydration, is in shock and cannot drink, is vomiting very severely and persistently and there are other serious complications, the administration of IV fluids should be started immediately. Adequate skilled nursing care and in−patient facilities must be made available.

If the patient can drink, ORS should be given by mouth while the drip is being set up. If IV fluids cannot be administered within 30 minutes, ORS can – as an emergency measure – be administered, under medical supervision, using a nasogastric tube. Ringer’s lactate is the best fluid for patients of all ages with all types of diarrhoea. If that is not available, normal saline may be used.

The patient should be reassessed every 1−2 hours. If hydration is not improving, the IV drip should be given more rapidly. As soon as the patient can drink, ORS solution is given in addition to the IV drip. The patient should be observed at least six hours after rehydration to be sure the mother can maintain hydration giving ORS solution by mouth. When there are no remaining signs of dehydration, the patient is discharged and the parents given instructions for continuing care at home.

Estimating Supply Requirements

Panel 1 provides an example of calculating the quantities of ORS required using some typical figures. One episode every three months, 20 per cent of the cases receiving ORS, is typical in many endemic situations, but higher or lower figures may be appropriate in some communities. Requirements are likely to be very much higher in camp situations, especially due to the higher coverage.

Calculation requires local estimates for:

• the percentage of children under five years of age in the total population;
• the average number of episodes requiring ORS per child every three months;
• the proportion of cases expected to receive ORS from health services and the probable wastage rates for packets.

For regular national programmes, a buffer stock of 25 per cent of annual requirements is normally recommended. A higher level may be appropriate in an emergency−affected area if further deterioration of the health situation is likely and especially if rapid replenishment of stocks cannot be guaranteed.

In health centres or emergency rehydration centres, oral rehydration solutions may be prepared from bulk ingredients. (Please Refer to Panel 2).

Surveillance for Diarrhoeal Disease

All health facilities and community−based health workers should maintain daily records of diarrhoea cases seen. This should be an integral part of the routine reporting on health. Records should include the degree of
dehydration at the time of presentation. Case definitions should be standardized and bloody diarrhoea recorded as a separate category. Any significant increase in the number of cases or in the appearance of cases of suspected cholera or bloody diarrhoea should be reported immediately.

- **Cholera** should be suspected:
  - in an area where the disease is not known to be present, a patient aged 5 years or more develops severe dehydration or dies from acute water diarrhoea;
  - in an area where there is a cholera epidemic, a patient aged 5 years or more develops acute watery diarrhoea, with or without vomiting.

- **Dysentery**: diarrhoea with visible blood in the stool is indicative of dysentery. These cases should be treated as suspected shigellosis. Clinics and community health workers should monitor data to detect and report specifically on any increase in the number or severity of cases, change in the type of diarrhoea, rise in diarrhoea–specific mortality or change in the demographic breakdown of cases.

**Possible UNICEF Inputs**

Depending on the assessment of actual needs and possibilities and the expected actions of other agencies, some of the following might be considered.

**For public education and social mobilization:**

- equipment and funds for the production of materials and the dissemination of information.

**For training of health personnel:**

- materials and funds for the training of health workers, including the reproduction and distribution of local language guidelines.

**For rehydration therapy:**

- ORS;
- nasogastric tubes;
- measuring jugs, water containers, cups, spoons, stirrers, cleaning materials, etc., for ‘ORT corners’ in existing health facilities and/or special centres;
- small quantities of Ringer’s lactate and complementary supplies and equipment for treatment of severe dehydration in centres where there are facilities and staff able to properly administer IV fluids;
- support for health information and reporting systems and logistics.

Note: Avoid overestimating the material requirements – e.g. the number of ORS packets – and underestimating the training, education and logistic needs.

**Further Guidance**


Centres for Disease Control (CDC), *Famine−Affected Refugee and Displaced Populations: Recommendations for Public Health Issues* (Diarrhoeal Diseases, pp 57–65), MMWR, Atlanta, July 1992


WHO, Immunization Policy (WHO/EPI/GEN/95.03 Rev. 1), Geneva, 1996


**Panels**

**Panel 1 – Calculating ORS Requirements (Examples)**

<table>
<thead>
<tr>
<th>CALCULATING ORS REQUIREMENTS (EXAMPLES)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In a ‘normal’ community situation:</td>
</tr>
<tr>
<td>The need for ORS is mainly for children under 5 years. On average, 2 packets of ORS are needed to treat a child. ORS requirements for a 3–month period can therefore be roughly estimated as follows:</td>
</tr>
<tr>
<td>• Total population (e.g. 100,000)</td>
</tr>
<tr>
<td>• Percentage of children under 5 in the total population (say 16%)</td>
</tr>
<tr>
<td>• Number of episodes per child every 3 months requiring ORS (say 1)</td>
</tr>
<tr>
<td>• Percentage of cases expected to receive packets (say 20%)</td>
</tr>
<tr>
<td>• 2 packets per episode</td>
</tr>
<tr>
<td>• Allowance for wastage (say 10%, therefore multiply by 1.10)</td>
</tr>
<tr>
<td>= Total number of packets needed every 3 months. (100,000 x 0.16 x 1 x 0.20 x 2 x 1.10) = 7,040, i.e. approximately 7,000 packets</td>
</tr>
</tbody>
</table>

In a camp situation (displaced persons):

| • Total population (e.g. 100,000) |
| • Proportion of children under−5 in the total population may be abnormal (say 25%). |
| • Number of episodes per child every 3 months is often higher than normal (say 2). |
| • Percentage of cases expected to receive packets may be high (say 75%). |
| • 2 packets per episode. |
| • Wastage less than ‘normal’ (say 5%, thus multiply by 1.05). |
| = Total number of packets needed for 3 months would be (100,000 x 0.25 x 2 x 0.75 x 2 x 1.05) = 78,750 packets, i.e. approximately 80,000 packets |

During outbreaks of cholera:

| • (Camp) population of 100,000 |
| • 0.2% of the total population in an area is typically afflicted in a severe outbreak. |
| • Coverage of cases may be very high (say 100%) in a camp situation but lower among a scattered population. |
| • On average, 6 packets of ORS are required to treat each case. |
- Allowance for wastage (say 10%, therefore multiply by 1.10)

= The additional requirement for dealing with the outbreak may be \((100,000 \times 0.002 \times 1.00 \times 6 \times 1.10) = 1,320\) packets, i.e. approximately 1,300 packets

Panel 2 – To Make 10 Litres of ORS Solution From Bulk Ingredients

<table>
<thead>
<tr>
<th>TO MAKE 10 LITRES OF ORS SOLUTION FROM BULK INGREDIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely dissolve the sugar and salts in the amounts shown below in 10 litres of water. Use drinking water: boiled water, cooled before use, or chlorinated water is best. If larger volumes are prepared, the amount of each ingredient should be increased proportionally. ORS solution should be used within 24 hours; after that time, the unused solution should be discarded and fresh solution prepared.</td>
</tr>
</tbody>
</table>

ORS solution:
- sodium chloride (common salt) 35g
- plus glucose, anhydrous 200g  
  or glucose, monohydrate 220g  
  or sucrose (common sugar, if glucose unavailable) 400g  
  plus trisodium citrate, dihydrate 29g  
  or sodium bicarbonate 25g  
  plus potassium chloride 15g

Chapter 1 – Annex 4: Containing Outbreaks of Cholera, Dysentery and Typhoid

Objective
To contain any epidemic outbreak as quickly as possible and offer treatment to those affected.

Strategies and Priorities
Epidemics of communicable disease can be precipitated by a variety of factors not necessarily connected with any other form of crisis. However, disasters and emergencies can create conditions favourable to the rapid spread of diseases already endemic in the area.

Any outbreak of communicable disease requires concerted, simultaneous action in relation to:

- epidemiological investigations;
- public health measures to prevent and reduce transmission; and
- treatment (correct case management) of individual cases.

To control cholera and epidemic shigellosis, which can easily become epidemic in overcrowded communities or camps, it is important to detect the disease when it first appears and take immediate action to treat patients and prevent transmission. Any report of an epidemic must be quickly investigated to check diagnoses.
(through laboratory analyses and detailed examination of clinical descriptions and associated epidemiological factors) and the actual rates of incidence.

Preparatory measures should be taken in anticipation of seasonal outbreaks in endemic areas or when an outbreak has occurred in a neighbouring country and can be expected to spread. In case of a major outbreak, special response measures are likely to be needed including the activation, or creation, of an inter−ministerial task force responsible for containing the outbreak and the assignment of additional medical and sanitation personnel including mobile teams. In any situation where peripheral health services are not prepared for an epidemic or are overwhelmed by it, mobile teams will be needed to:

- collect stool specimens for laboratory testing;
- establish and operate temporary treatment centres;
- provide on−the−spot training in case management to local workers;
- supervise environmental sanitation and disinfection activities;
- carry out health education activities in the community; and
- provide logistical support to ensure the delivery of essential supplies.

Team typically include doctors, nurses, paramedical staff, health educators and technicians.

The public health measures needed are broadly similar in all cases − for cholera, dysentery and typhoid − focusing on hygiene and attention to water supply and environmental sanitation, with only slight differences in emphasis. Vaccinations and mass chemoprophylaxis are not appropriate in any case. Treatment regimens are specific to each disease.

A strong health promotion programme and well−functioning disease surveillance and reporting systems are the best preparation for and prevention against epidemics of cholera, dysentery and most other communicable diseases.

Cholera

Cholera is caused by the ingestion of an infectious dose of cholera vibrios, producing acute, severe diarrhoea, often with ‘rice−water’ stools. Dehydration is more rapid and severe than in other types of diarrhoea and adults are affected as well as children. Adults may lose 15% of fluid in a 24−hour period. A child with severe cholera may die within a few hours of the onset of the disease. In severe, untreated cases, over 50% of patients may die. If cases are recognized in time and treated properly, death is uncommon, with less than 1% case fatalities.

Feacally contaminated water is the most common vehicle for the transmission of infection, either directly or through the contamination of food, especially seafood and fresh vegetables. Food may also be contaminated by the soiled hands of infected persons.

Preparedness for Cholera

Specific preparatory measures should be taken in two situations:

- when an outbreak has occurred in a neighbouring country or area and can be expected to spread; and
- in anticipation of the usual cholera season in an area where it is endemic.

In such cases, timely action must be taken to:

- strengthen surveillance and reporting, particularly along the routes of possible disease introduction and in cholera−receptive areas (characterized by overcrowding and unhygienic environments);
- ensure that health workers in the area(s) at risk are trained in the management of acute diarrhoeas including cholera; and
• assure modest buffer stocks of ORS, IV fluids, antibiotics and laboratory supplies, health education materials and supplies for water treatment and sanitation measures, in the areas at risk.

At the same time, continue and intensify health promotion and education among the population focusing on immediately practicable measures in food hygiene, hand washing and the safe disposal of excreta and ensure the safety of water supply and the implementation of food safety measures (especially in feeding centres).

Close coordination between the ministry of health, WHO, UNICEF, bilateral assistance, NGOs and other concerned agencies is essential.

Priorities during a Cholera Outbreak

Priority must be given to:

• the prompt identification and treatment of individual cases; and
• intensive health education and social mobilization with supporting public health measures.

This must be supported by:

• epidemiological investigations to determine the extent of the outbreak and primary modes of transmission so that specific control measures can be applied; and

• assured availability at community level of all needed supplies (for treatment, health education and public health measures), which requires reliable distribution systems, the careful monitoring of stocks and usage rates and prompt action to replenish stocks when needed.

Immediate action is needed to mobilize resources to manage the outbreak.

Vaccination, mass chemoprophylaxis and travel and trade restrictions are not effective in controlling cholera. On the contrary, they risk creating unjustifiable complacency in both the community and health services and waste resources which could be better used in implementing other, more effective measures. (The same applies to typhoid, see below.)

A cholera outbreak should be suspected if:

• a patient older than 5 years develops severe dehydration or dies from acute watery diarrhoea; or

• there is a sudden increase in the daily number of patients with acute watery diarrhoea, especially patients who pass the ‘rice water’ stools typical of cholera.

A case of cholera should be suspected:

• in an area where the disease is not known to be present, a patient aged 5 years or more develops severe dehydration or dies from acute water diarrhoea;

• in an area where there is a cholera epidemic, a patient aged 5 years or more develops acute watery diarrhoea, with or without vomiting.

Any suspected case should be reported immediately to the national health authorities who are also required to notify WHO. Treatment and preventive measures should start immediately to reduce the risk of contamination of the environment.

Cholera is confirmed when laboratory tests isolate cholera vibrios (in a stool sample or rectal swab) from any patient with diarrhoea. Analysis will also determine drug sensitivity. Once cholera has been confirmed in an area, it is not necessary to attempt to confirm every clinical case. Each patient presenting symptoms should be treated for cholera. Specimens should be taken and analyzed from occasional patients to monitor the epidemic. (Facilities and systems to collect and analyze stool samples must be assured.)
Identification and Treatment of Cholera Cases

People (and health workers) must be educated, and the community as a whole be mobilized, to recognize the symptoms and bring patients immediately to a health facility. Cases should be treated near their homes to decrease spread of the disease.

Treatment consists of correcting dehydration, usually with ORS and antibiotic therapy. Intravenous rehydration may be required initially for up to 20 per cent of cases: oral rehydration is normally sufficient for more than 80 per cent of cases. As soon as vomiting stops, food should be offered in frequent small amounts. Breastfeeding of infants and young children should be continued.

Most cases can be treated in existing health centres if sufficient ORS, intravenous fluid (Ringer’s lactate) and appropriate antibiotics are available and if health workers are trained in diarrhoea case management. If appropriate facilities, supplies and trained staff are not available or are far away or if there are too many cases to be handled by existing facilities, it will be necessary to establish temporary emergency treatment facilities in affected communities. These may be in huts, tents or public buildings.

Sugar−salt solutions and other home−made fluids can prevent or delay the onset of dehydration while the patient is brought to a health facility, but they are not adequate to treat dehydration caused by cholera. Whenever cholera epidemics are suspected, the population needs to be educated to use ORS and supplies must be made available. Wherever ORS packets are limited, available packets should be reserved for use in remote areas, while solutions are prepared from bulk ingredients in hospitals and health centres.

To estimate the number of cases that can be expected in a country or area affected by a cholera epidemic, an attack rate of 0.2 per cent can be used (i.e. 200 cases may be expected to occur in a population of 100,000). In a severe epidemic, the national attack rate may be 1.0 per cent or higher and may reach 10–20 per cent in some areas. However, calculations based on an attack rate of 0.2 per cent should allow enough supplies to meet the needs during the first weeks of the epidemic, during which time the requirements can be reassessed.

Panel 1 indicates the quantities of supplies that may be required to treat 100 cases, of which 20 may initially require intravenous fluid. ORS is required as a follow−up for these 20 cases and also for the other 80 cases. One hundred is the number of cases that may be expected during an outbreak in a population of 50,000 in a cholera−receptive area. This panel lists the drugs that are appropriate in most areas/situations. However, if the strain of cholera is resistant to these, other drugs must be used (see Panel 2).

Panel 3 provides brief guidelines (lists key points) for the establishment of temporary emergency treatment facilities/centres where needed. Panel 4 lists items needed for diagnostic purposes.

Selective chemoprophylaxis for very close contacts of cholera patients may be useful and justified if the secondary attack rate in affected families exceeds 20 per cent (which is not often the case) and if drug administration (a single dose of doxycycline) can be closely supervised. Too liberal a use of drugs for prophylaxis is not useful and can promote the development of antibiotic resistance.

Most cases can be treated in existing health centres if rehydration materials and antibiotics are available and health workers are trained in the management of diarrhoea. If appropriate facilities, supplies and trained staff are unavailable or far away, or if there are too many cases to be handled by existing facilities, it will be necessary to establish emergency treatment facilities in affected communities.

Public Health, Education and Social Mobilization during a Cholera Outbreak

General health promotion and education activities must be intensified with special emphasis on:

- food and personal hygiene;
- the boiling (or chlorination) and safe storage of water used for drinking or in food preparation;
• the sanitary disposal of excreta, especially children’s excreta, in latrines; and

• seeking help immediately for any individual, child or adult, suffering acute watery diarrhoea and subsequent signs of dehydration.

Voluntary organizations, community and religious leaders, teachers, students and youth and women’s groups should be mobilized to inform and educate community members, to distribute soap and ensure its frequent use and to help in detecting and reporting cases. Health and other community–based workers should be encouraged to make home visits to observe and suggest improvements in hygiene practices. (Health workers involved in treating cholera patients must also observe strict personal hygiene, washing their hands with soap after examining each patient.) A supply of suitable chemicals for treating water and narrow–mouthed containers with covers for storing water, can help to reduce secondary transmission within a family.

At the community service level, action must be taken to:

• ensure the safety of water supplies, by ensuring adequate chlorination of public water supply systems and checking other water sources used by the population, especially surface water and closing access to any found to be contaminated until it is made safe;

• ensure facilities for the sanitary disposal of human waste appropriate to local conditions, normally by assuring the construction, use and maintenance of latrines.

Particular care must be taken to ensure such facilities wherever large numbers of people congregate, e.g. at fairs, funerals and religious festivals.

Where pit latrines are used in an area affected by cholera, the pit should be coated each day with a layer of unslaked lime.

Patients’ bedding and clothing should be disinfected by stirring them for 5 minutes in boiling water. Bedding, including mattresses, can be disinfected by thorough drying in the sun. To minimize contamination of the washing area, the patient’s clothing and other articles can be disinfected by drying them in the sun before washing.

Liquid waste (stools and vomit) from cholera patients should be sterilized or buried. It can be mixed with disinfectants such as cresol or Lysol. (A prepared acid solution may be used, with care, in larger health facilities if toilet and other installations are made of ceramic materials.) Semi–solid waste is best disposed of by incineration, provided that the incinerator used is designed to destroy contaminated waste. The waste should be kept separate from other kinds of waste and, if possible, put into single–use, moisture–proof bags and burned in the bags. Carts used to transport the waste must be cleaned regularly and used only for that purpose.

Education and, if necessary, legislation and regulations should be used to limit funeral gatherings, ritual washing of the dead and funeral feasts, in order to reduce risks of spreading infection. Health workers can be helpful in supervising the use of hygienic practices on these occasions, where feasible.

**Epidemic Dysentery/Shigellosis**

Epidemics due to Shigella dysenteriae type 1 (Sd1) are increasingly common, particularly in Asia and Africa. This is the most virulent, highly infectious form of the shigella and it can result in serious systemic complications and death. It is most often severe or fatal in young children, especially infants and among the elderly and malnourished. It is often resistant to most of the common antibiotics recommended to treat Sd1. Infection is most common in overcrowded areas with poor sanitation, sub–standard hygiene and unsafe water supplies. Risks are greatest during hot, wet weather.

Preparedness measures are broadly similar to those for cholera.
Identification and treatment of shigellosis

People and health workers must be educated and the community as a whole mobilized to bring any case of bloody diarrhoea to a health facility. A dysentery outbreak should be suspected whenever there is an unusual increase in the weekly number of patients with bloody diarrhoea or deaths from bloody diarrhoea.

Case management normally consists of:

- the administration of an appropriate antimicrobial drug – selected on the basis of analysis of the local strain and drug resistance patterns;

- increased fluid intake (using ORS or other home-prepared solutions) to prevent dehydration; and

- continued feeding.

Most patients can be treated at home, but any showing signs of dehydration should be referred immediately to a health facility (or emergency treatment centre), where dehydration can be corrected using ORS or, if severe, IV fluid (Ringer’s lactate).

Continued provision of nutritious food is important, but patients may need to be coaxed to eat. Frequent small meals with familiar foods are usually better tolerated than a few large meals. Infants and young children should be breastfed as often and as long as they want. Those who are over four months should be offered their usual foods in addition.

Drugs should be selected on the basis of recent susceptibility testing of Sd1 strains from a nearby area or, after an epidemic develops, obtained locally. When the presence of Sd1 has not been confirmed or its antimicrobial susceptibility is not yet known, nalidixic acid should be selected until more precise information is available.

Chemoprophylaxis – mass administration of antimicrobial drugs – is never indicated: it has not been shown to be effective and can hasten the emergence of resistant strains, making treatment of the disease more difficult.

The individuals at greatest risk of death and to whom priority should be given in the administration of selected antimicrobials when supplies are limited, are:

- children less than 5 years of age, especially infants, severely malnourished children (<70% weight–for–height/length) and children who have had measles in the previous 6 weeks;

- adults 50 years of age and older;

- anyone who is dehydrated, has had a convulsion or is seriously ill when first seen;

- older children and adults who are obviously malnourished.

Health Education and Public Health Measures against Shigellosis

In contrast to cholera, the infectious dose is low and transmission by direct person-to-person is common. All aspects of hygiene and food safety are important and measures to ensure safe drinking water and the safe disposal of human waste are required, as for cholera, but top priority is handwashing with soap after defecation, after cleaning a child who has defecated, after disposing of a child’s stools, before preparing or handling food and before eating.

Breastfeeding of infants and young children should be promoted. Infants and children who are breastfed have fewer episodes of diarrhoea or dysentery due to shigella and, when these do occur, they are less severe than in those who are not breastfed. This protection is greatest in infants who are exclusively breastfed until 4–6 months of age, but remains significant when breastmilk is given with other foods even into the third year of life.
In health facilities, provide plenty of water and soap for handwashing, preferably in easily accessible, highly visible locations. Special care must also be taken to dispose of the stools of patients in a latrine or toilet (if this is not possible, bury them) and to wash and disinfect the clothes and bed linen of patients frequently. Workers who care for patients must not prepare or serve food.

**Typhoid Fever**

Typhoid is an acute illness caused by *Salmonella typhi*, usually ingested with food or water that has been contaminated from the faeces of an infected person or carrier. Priority should be placed on public health measures:

- Cleanliness is the best prevention and special attention shall be given to food hygiene and the availability and use of sanitation facilities and safe water.
- Chloramphenicol is the drug of choice for treatment. If the local strain is resistant, ampicillin or amoxicillin can be used.

Sick persons should not handle food. They should be isolated from others while being treated. Mass vaccination with currently available vaccine is not recommended.

**Possible UNICEF Inputs**

The expertise and resources of WHO and WHO collaborating centres should normally be swiftly mobilized by the government whenever international assistance is required to control an epidemic. Where the health of children is directly at risk, some complementary inputs from UNICEF may be necessary. Depending on the assessment of actual needs and possibilities, some of the following inputs might be considered:

- specifically focused health education and social mobilization programmes among the most vulnerable communities;
- support for special training for health workers;
- support for in-country transport and distribution of priority supplies and personnel (transport may be temporarily diverted from other programmes);
- laboratory diagnostic supplies;
- specific drugs required for treatment, especially ORS.

**For cholera and shigellosis:**

- support to sanitary surveys and hygiene and sanitation measures (especially disposal of human excreta, provision of soap, etc.);
- support to water supply improvement measures, including chlorination;
- support to rehydration therapy;
- preparedness measures in areas into which current outbreaks elsewhere may spread.

**For typhoid:**

- support for measures to improve water supply (including chlorination) and sanitation.

Where specific epidemics are common – virtually annual events – in particular localities, provision to respond to the predictable needs for assistance should be included in the regular UNICEF health programme budget and recourse be made to ‘emergency’ assistance processes only if the epidemic takes on unusually major proportions or generates extraordinary needs.
Further Guidance

WHO, Guidelines for the control of epidemics due to Shigella dysenteriae type 1, (WHO/CDR/95.4), 1995


WHO, Guidelines for cholera control, 1993

WHO, Factsheets on environmental sanitation for control of cholera and other epidemic diseases, 1996

Panels

Panel 1 − Antibiotics Used to Treat Cholera

<table>
<thead>
<tr>
<th>ANTIBIOTICS USED TO TREAT CHOLERA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antibiotic</strong></td>
</tr>
<tr>
<td>Doxycycline</td>
</tr>
<tr>
<td>single dose −−−−−</td>
</tr>
<tr>
<td>Tetracycline</td>
</tr>
<tr>
<td>4 times per day for 3 days</td>
</tr>
<tr>
<td>Trimethoprim (TMP) − sulfamethoxazole (SMX)</td>
</tr>
<tr>
<td>twice a day for 3 days</td>
</tr>
<tr>
<td>Furazolidone</td>
</tr>
<tr>
<td>4 times per day for 3 days</td>
</tr>
</tbody>
</table>

<sup>a</sup> Erythromycin or chloramphenicol may be used when the antibiotics recommended above are not available, or where Vibrio cholerae O1 is resistant to them.

<sup>b</sup> Doxycycline is the antibiotic of choice for adults (except pregnant women) because only one dose is required.

<sup>c</sup> TMP−SMX is the antibiotic of choice for children. Tetracycline is equally effective; however, in some countries it is not available for paediatric use.

<sup>d</sup> Furazolidone is the antibiotic of choice for pregnant women.

Panel 2 − Estimated Minimum Supplies Needed to Treat 100 Patients During a Cholera Outbreak

<table>
<thead>
<tr>
<th>ESTIMATED MINIMUM SUPPLIES NEEDED TO TREAT 100 PATIENTS DURING A CHOLERA OUTBREAK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehydration supplies&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
650 packets ORS (for 1 litre each)
120 litres Ringer’s lactate solution\(^a\), with IV−giving sets
10 scalp−vein sets
3 nasogastric tubes, 5.3 mm OD, 3.5 ID (16 French), 50 cm long for adults
3 nasogastric tubes, 2.7 mm OD, 1.5 ID (8 French), 38 cm long for children
Antibiotics
For adults:
60 capsules doxycycline, 100 mg (3 capsules per severely dehydrated case)
OR 480 capsules tetracycline, 250 mg (24 capsules per severely dehydrated case)
For children:
300 tablets trimethoprim−sulfamethoxazole, TMP 20 mg + SMX 100 mg (15 tablets per severely dehydrated case)

If selective chemoprophylaxis is planned, the additional requirements for four close contacts per severely dehydrated patient (about 80 people) are:
240 capsules doxycycline, 100 mg (3 capsules per person)
OR 1,920 capsules tetracycline, 250 mg (24 capsules per person)
Other treatment supplies
2 large water dispensers with tap (marked at 5− and 10−litre levels) for making ORS solution in bulk
20 bottles (1 litre) for ORS solution (e.g. empty IV bottles)
20 bottles (0.5 litre) for ORS solution
40 tumblers, 200 ml
20 teaspoons
5 kg cotton wool
3 reels adhesive tape

\(^a\) The amount of supplies listed allows enough intravenous fluid followed by ORS for 20 severely dehydrated patients and the exclusive use of ORS for the other 80 patients.

\(^b\) If Ringer’s lactate solution is not available, substitute normal saline.

Panel 3 − Establishing Emergency Treatment Facilities/Centres

<table>
<thead>
<tr>
<th><strong>ESTABLISHING EMERGENCY TREATMENT FACILITIES/CENTRES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any hut, building or, if necessary, tent can be used as a temporary facility, provided it is part of the affected community, so that patients do not have to travel and it has:</td>
</tr>
<tr>
<td>• convenient hand−washing facilities;</td>
</tr>
</tbody>
</table>
• preferably many toilets (as in schools) or an alternative means for disposing stools and vomitus of patients (otherwise appropriate, safe facilities for sewage disposal may need to be provided);

• space to house the number of patients requiring treatment;

• adequate washing area nearby or preferably within premises and enough clothes–drying space/facilities;

• a distance of 3 feet between beds of patients on all sides;

• an adequate number of trained volunteers;

• enough supplies, as mentioned previously for the treatment of patients;

• large vessels to prepare adequate quantities of ORS, and enough of them; smaller vessels, glasses, spoons, covers for administering to patients;

• for holding IV bottles, wires could be set up from where they can be hung by hooks;

• a separate outpatient room/tent, where patients with mild symptoms can be examined and prescribed treatment, given instructions and sent home.

Panel 4 – Diagnostic Laboratory Supplies for Presumptive Identification of Vibrio Cholerae O1 at a Peripheral Laboratory

<table>
<thead>
<tr>
<th>DIAGNOSTIC LABORATORY SUPPLIES FOR PRESumptive IDENTIFICATION OF VIBRIO CHOLERAE O1 AT A PERIPHERAL LABORATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific items for cholera diagnosis</td>
</tr>
<tr>
<td>• 100 rectal swabs</td>
</tr>
<tr>
<td>• 500 g Cary–Blair medium</td>
</tr>
<tr>
<td>• 3 x 300 g TCBS medium or 250 g trypticase, 250 g sodium taurocholate, 2 x 250 g gelatin, 25 g potassium tellurite</td>
</tr>
<tr>
<td>• 5 x 2 ml polyvalent O–Group 1 cholera diagnostic antiserum</td>
</tr>
</tbody>
</table>

| General laboratory supplies (should already be available in a well–equipped bacterial laboratory)           |
| • 25 g sodium desoxycholate                                                                                  |
| • 5 g tetramethyl–p–phenylenediamine dihydrochloride                                                          |
| • 250 g Kligler’s iron agar                                                                                    |
| • 500 g nutrient agar                                                                                        |
| • 1 kg Bacto–peptone culture medium                                                                           |
| • 500 Petri dishes (9 cm)                                                                                     |
| • 1000 test–tubes (13 x 100 mm)                                                                               |
| • 1000 disposable Bijou bottles                                                                               |

Panel 5 – Some Public Health Supply Requirements

<table>
<thead>
<tr>
<th>SOME PUBLIC HEALTH SUPPLY REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• disinfectant (e.g. cresol or Lysol)</td>
</tr>
<tr>
<td>• muriatic acid</td>
</tr>
</tbody>
</table>
Chapter 1 – Annex 5: Control of Acute Respiratory Infections

Objective

To reduce mortality in children due to acute respiratory infections, particularly pneumonia.

Priorities and Strategies

Acute respiratory infections (ARIs) are among the principal causes of child sickness and death in emergency situations, particularly among children in refugee and other displaced populations. Susceptibility is increased by overcrowding, malnutrition, low birth weight and a decrease in immunity due to various other causes. Pneumonia is likely to be especially prevalent during cold and wet seasons. In developing countries, 25 to 30 per cent of deaths among children under five are caused by ARI and 90 per cent of them are attributable to pneumonia.

Among ARIs, pneumonia is the most dangerous form and the most important cause of death. Although a large proportion of pneumonia episodes are caused by bacterial infections that are treatable with antibiotics, case fatality rates are high in many situations. Young children with pneumonia, especially those within the first two months of life, may die within 3 days of the onset of the illness, often before any contact is made with the health system.

Many deaths caused by pneumonia may be prevented by early recognition of infection by mothers and health workers and by correct treatment.

Strategies to reduce ARI deaths and morbidity at first-level health facilities and through community-based practitioners include:

- training health workers to recognize and provide appropriate, standardized treatment for childhood pneumonia and other ARIs; and

- ensuring the availability and regular supply of necessary drugs to first-level health facilities and community-based practitioners;

- ensuring appropriate referral services for the treatment of severe cases of pneumonia;

- educating parents to recognize the danger signs and symptoms of pneumonia and to seek medical help;

- reducing susceptibility of infants and young children to ARIs by promoting breastfeeding, ensuring immunization, improving shelter and ensuring adequate warmth (heating, clothing and blankets).

Pneumonia requires prompt treatment with an antibiotic after assessment by a trained health worker. Antibiotics can be given at home, except in cases of severe pneumonia that require referral for in-patient care at a hospital or health centre. There is no simple remedy that parents or other caregivers can use at home and little they can do on their own to reduce the severity once pneumonia sets in. Many deaths occur because
help is sought too late, others because inappropriate treatment is given.

Staff of primary care facilities (health centres, dispensaries, etc.) and community health workers should be trained to:

• recognize the severe and less−severe forms of pneumonia and distinguish them from other, milder forms of ARI (coughs and colds) (see Panel 1);

• provide treatment for and follow up non−severe cases;

• refer severe cases to a referral centre, wherever feasible.

Parents (and other caregivers) need to be taught to:

• recognize the signs of pneumonia (see Panel 1) and seek medical help without delay for any child who has a cough and fast or difficult breathing (this should be a priority element in health education efforts in any situation where ARIs are prevalent); and

• provide supportive home care to children under treatment, including continued feeding, adequate fluid intake, use of safe and appropriate cough/cold remedies, prompt referral if there are signs of deterioration.

The importance of breastfeeding and immunization, including the benefits in reducing susceptibility to ARIs, must be emphasized in general health promotion activities.

Treatment of Pneumonia and Other Forms of ARI

Children showing danger signs or chest in−drawing (severe pneumonia) and cases of pneumonia with severe malnutrition, should be treated as in−patients at a hospital or at a health centre.

Non−severe pneumonia is treated at home after assessment by the health worker. Suitable antibiotics are cotrimoxazole (trimethoprim + sulfamethoxazole), amoxycillin or ampicillin tablets or syrup. (Cotrimoxazole should be avoided in newborns.) In all cases the duration of treatment is 5 days. The child should be reassessed after two days. If the condition is no better after two days of treatment, the antibiotic may be changed. A child who shows danger signs on reassessment should be referred to in−patient care.

If for any reason referral to a hospital is not possible, the child should be treated at home with antibiotics. The best choice is intramuscular chloramphenicol, if it is available. If it is not, intramuscular benzyl penicillin or the oral antibiotic used for non−severe pneumonia may be used. The child should be followed up at least daily to ensure that antibiotics are being given and that supportive care, including extra fluids and continued feeding, is adequate.

Wheezing children with fast breathing or chest in−drawing should be given a rapid−acting bronchodilator and reassessed after 30 minutes. If this relieves the fast breathing/chest in−drawing, the child may be given oral salbutamol for three days. If these signs are not relieved, the child should be treated as for pneumonia – or severe pneumonia if there is respiratory distress or any danger sign – and given salbutamol in addition.

Antibiotics should not be used for coughs or colds when there are no signs of pneumonia. Caregivers should be advised to give extra fluids, maintain feeding and give tea, honey or some other soothing remedy to relieve a sore throat. High fever (39oC or more) should be treated with paracetamol; wheezing, with a rapid−acting bronchodilator if there is respiratory distress or with oral salbutamol if there is no distress.

Possible UNICEF Inputs

• Essential drugs: the basic antibiotics required are included in the standard WHO Emergency Health Kit. As with other drugs for the treatment of diseases that particularly affect children, UNICEF should ensure the monitoring of usage rates and, as soon as possible, move to the provision of basic drugs in bulk in appropriate quantities. If, for logistic reasons, it is
necessary to continue supplying kits for an extended period, propose adjustment in the contents of kits to observed local requirements after the first few months.

- Funding and materials for the training of basic health workers (training on correct management of ARI linked with other priority training needs).

- Funding and materials for education of mothers (in the context of overall health education programme activities).

Provision of oxygen and other supplies and equipment for referral centres should normally be assured by specialized medical agencies.

Further Guidance

WHO, *Management of the Child with Cough or Difficult Breathing*, Diagnostic and Treatment Chart (WHO/ARI/94.31), 1994 (available as a pocket-sized version)

WHO, *Acute Respiratory Infections in Children: Case Management in Small Hospitals in Developing Countries*, Programme for the Control of Acute Respiratory Infections (WHO/ARI/90.5), 1990


Panel

Panel 1 – Signs of Pneumonia

<table>
<thead>
<tr>
<th>SIGNS OF PNEUMONIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Danger signs (very serious disease)</td>
</tr>
<tr>
<td>• Young infants (&lt;2 months) stop feeding well; have convulsions; are abnormally sleepy or difficult to wake; make a harsh noise during inspiration (stridor); wheeze, or have a fever or low body temperature.</td>
</tr>
<tr>
<td>• Children (2 months to 5 years) are not able to drink; have convulsions; are abnormally sleepy or difficult to wake; make a harsh noise during inspiration (stridor), or are severely malnourished.</td>
</tr>
<tr>
<td>Action: immediate hospitalization after an initial dose of antibiotic.</td>
</tr>
</tbody>
</table>

**Chest in-drawing** is a sign of severe pneumonia in children 2 months to 5 years. In young infants, severe chest in-drawing (the lower chest wall goes in when the child breathes in) alone is a sign of severe pneumonia.

Action: health workers should give the first dose of antibiotic immediately and refer the child to the hospital, if feasible.

**Fast breathing** is the key sign of pneumonia and should be recognized by mothers as well as health workers. Health workers should learn to count the child’s breathing:
Chapter 1 – Annex 6: Essential Drugs and Supplies

Objective

To ensure the availability and rational use of necessary essential drugs and other expendable supplies for community level health services.

Delivering Essential Items

Where there are virtually no stocks on hand and whenever the capacity to receive, sort and repack drugs is limited:

• deliver drugs in set-packed kits ready for immediate distribution to user units;
• quantities in each kit should be appropriate to the size of population served by the average health post.

Consider delivering drugs in bulk or accepting donations of bulk-packed drugs only where central pharmaceutical stores are still well organized and operating efficiently, despite the emergency.

The WHO Emergency Health Kit, available from Supply Division, may be appropriate in the early stages of an emergency.

Where significant stocks and organizational capacity do exist and after the first 2–3 months in all instances, tailor any on-going inputs to the observed usage rates of different items in the basic list, to in-country stock levels and any ongoing local production.

Policies for dispensing and distributing drugs should take account of established local practices and long-term policies as well as immediate needs. Try to avoid undermining any actual or proposed mechanisms of community self-reliance, e.g. village pharmacies selling at cost price by large-scale (but short-term) free distribution of drugs. If necessary, consideration might be given to increasing the operational stocks of any such pharmacies for a limited, initial period which is agreed to in advance by all concerned.

Practical Considerations

Instructions for the use of available drugs should be issued in a locally-understood language. They must be carefully phrased – simple, unambiguous and fully comprehensible to the least trained of likely users.

Except when set-packed for immediate distribution, each different type of drug should be packed separately and outer packages clearly marked to facilitate sorting and storage.

Both the inner and outer packaging of all drug consignments should be robust and weather-proof. All drugs supplied should have a remaining shelf life of at least 6 months and the expiry date be printed on the outer carton.

Emergency Health Kit

The WHO Emergency Health Kit is designed to establish a clinic and provide basic drugs to meet the essential needs for 10,000 persons for an initial 3 months. In practice, the drugs and expendable supplies are
sometimes used up more quickly during the early stages of an emergency.

The kits are widely used by many organizations, including UNHCR, ICRC, IFRC and major NGOs, thereby achieving a fairly high degree of standardization of basic drugs used in the initial stages of an emergency. Similar kits are stocked by WHO, UNHCR and some NGOs as well as UNICEF–Copenhagen.

The kit includes antimalarial drugs which will not be required in some regions. The cost of these is not great and, after study, WHO and collaborating organizations have agreed not to specify different kits to be stocked for different regions. The standard kit should be used to meet initial needs in all cases and modified kits appropriate to local epidemiology be defined if and when appropriate for follow-up orders.

The basis of the kit: The composition of the kit is based on epidemiological data, population profiles and disease patterns typical of emergency situations and certain assumptions borne out by experience as follows:

- the assumption that clinics will usually be staffed by health workers with only basic training, who will treat symptoms rather than diagnosed diseases and will refer patients who need more specialized treatment;

- the assumption that half the population is 0–14 years of age (5,000 persons).

- for each half of the population, an estimate of the likely numbers of the more common symptoms or diseases present in a 3–month period at the early stage of an emergency and the assumption that standardized schedules will be used to treat these.

Emergency needs: The drugs listed are intended to cover initial needs, pending a proper assessment of, among other things:

- the demographic pattern of the community;

- the physical condition of individuals;

- the incidence of symptoms and diseases as determined, for example, from clinic and health centre records and nutritional surveillance;

- the prevalence of symptoms as determined, for example, from household and nutrition surveys;

- the causes of mortality and morbidity;

- likely seasonal variations of symptoms and diseases;

- the likely impact of improved public health measures;

- local availability of drugs and equipment, taking into account national drug policies;

- drug resistance;

- the capabilities of health workers and

- the referral system.

When this assessment has been made, a special list should be drawn up in light of the situation and appropriate arrangements made to supply the necessary quantities.

Exclusions: The kit does not include vaccines or drugs to control certain communicable diseases. Vaccines and special drugs should be ordered separately in line with WHO recommendations and national policies, in agreement with the national health authorities.
Storage and Distribution Systems

Rehabilitate the central and district-level medical stores, wherever required. Assist in re-establishing planning and management systems (training, computers, etc.). At all locations where drugs need to be stored, arrange for:

- the best possible storage facilities;
- prompt inspection and sorting of incoming consignments;
- proper inventory control; and
- systematic monitoring of requisitions.

Pharmacy students may be mobilized to operate temporary pharmacy stores in the field and to reinforce staff at central and regional stores. If in-country expertise is limited or depleted, one or more experienced pharmacists may be brought in quickly to help establish central and regional medical stores.

Possible UNICEF Inputs

Depending on the assessment of actual needs and capacities, some of the following inputs might be considered:

- sets of basic drugs (by diverting stocks on hand or en route for regular programmes, local purchases or air deliveries from Supply Division);
- quantities of specifically needed drugs and other supplies – soap, disinfectant, etc.;
- transport for the internal distribution of drugs;
- local costs for the establishment and operation of necessary medical stores;
- training for management and rational use of essential drugs;
- experienced pharmacists’ services.

Give priority to ensuring adequate supplies of drugs and other supplies relevant to the most basic, current health problems affecting children and mothers. Coordinate closely with other potential donors of drugs. The same basic list of requirements will often have been forwarded by the government to various potential donors.

For all requests:

- check the numbers of people to be served and compare the quantities with those in the WHO emergency health kit lists;
- seek specific explanations for any major discrepancies and justification for any requests for items not in the WHO lists or specific brand-name products.

Evaluate offers of in-kind donations of drugs very carefully, namely ‘unsolicited contributions’, ‘doctors’ samples’ and sophisticated non-essential drugs should normally be refused.

Further Guidance


WHO *Emergency Health Kit*, 1991

WHO. Treating measles in Children (WHO/EPI/TRAM/97.02), Geneva, 1997
Chapter 1 – Annex 7: Management, Control and Prevention of the Most Common Communicable Diseases

Objectives

- To contain an outbreak of meningitis, yellow fever, measles, malaria and other communicable diseases as quickly as possible and offer treatment to those affected.
- To reduce the mortality, morbidity and transmission of tuberculosis.

Strategies and Priorities

Epidemics of communicable diseases can be precipitated by a variety of factors not necessarily connected with any form of crisis. However, disasters and emergencies can create conditions favourable to the rapid spread of diseases already endemic in the area.

In case of a major outbreak, priority must be given to:

- the prompt identification and treatment of individual cases, and
- intensive health education and social mobilization, with supporting public health measures, focusing in particular on overcrowded communities and camps, to contain the epidemic.

Preparatory measures should be taken in anticipation of seasonal outbreaks in endemic areas or when an outbreak has occurred in a neighbouring country, with the expectation that it might spread.

In case of a major outbreak, special response measures are likely to be needed, including the activation or creation of an inter-agency task force responsible for containing the outbreak and the assignment of additional medical and sanitation personnel, including mobile teams. Teams typically include doctors, nurses, paramedical staff, health educators and technicians, vector control specialists and epidemiologists.

Voluntary organizations, community and religious leaders, teachers, students, youth and women’s groups should be mobilized to inform and educate community members and to help in detecting and reporting cases.

Meningitis

Meningitis is endemic in many parts of the world, but epidemics of meningococcal meningitis (Serogroups A or C) occur particularly in the sub-Saharan ‘meningitis belt’ extending from Senegal to Ethiopia. There, seasonal epidemics occur every few years, normally during the dry season. Serogroups B and W 135, generally associated with sporadic disease, may cause some upsurges or outbreaks and has been associated with epidemics outside Africa. Mortality is often high, typically reaching 10 per cent even when appropriate antibiotic therapy is available.

It can reach 70 per cent in the absence of such treatment. Outbreaks are particularly dangerous when the population is malnourished and living in crowded conditions.

Surveillance is crucial to early and effective control. Clear reporting arrangements must be established: reporting on meningitis should be an integral part of the basic health information reporting system in any area where epidemics are known to occur. When an outbreak occurs, it must be closely monitored through weekly
reports of new cases. Priority must be given to determining the etiology and serogroup and the antibiotic resistance patterns, by laboratory analysis of specimens of cerebral spinal fluid (CSF).

Epidemic Control

Control is by mass vaccination using the vaccine appropriate to the particular strain.

In a large population (>30,000), a rate of 15 cases per 100,000 population per week for two consecutive weeks can be used as a threshold for initiating mass vaccination. A lower rate may be appropriate among displaced populations. If the population is relatively small (e.g. <30,000 people) or is unknown, a weekly doubling in the number of cases over 3 weeks – e.g. 2 to 4 to 9 cases per week over three weeks – should prompt consideration of mass vaccination. Priority for vaccination (which is relatively expensive) should be given to children and young adults 2–25 years of age.

If it is logistically feasible, the household contacts of identified cases should be checked for vaccination status and immunized, if necessary. However, it may be simpler to organize a targeted mass immunization campaign. Because cases of meningococcal meningitis are likely to occur in clusters, it may be most efficient to focus the vaccination campaign on the affected areas first.

Vaccination during non-epidemic periods is generally not considered to be an effective measure because of the short duration of protection. If there are compelling reasons to believe that the population is at high risk for an epidemic, preventive vaccination in overcrowded areas before the meningitis season may be warranted.

Mass chemoprophylaxis is ineffective and is not recommended. The usefulness of chemoprophylaxis of case contacts – using sulfonamides or other drugs depending on the strain – is controversial.

Treatment

Treatment is with antibiotics and should follow the established local treatment schedule. It is important that treatment start early. In most developing countries, treatment of meningococcal meningitis is normally by a single intramuscular injection of long-acting chloramphenicol in oil suspension. A second dose may be needed in about 25 per cent of cases. Patients should be admitted as inpatients and monitored closely to determine whether the additional dose is required.

Ampicillin or penicillin are also used. Where intensive nursing care and necessary medical equipment are available (normally in more developed countries), intravenous-administered penicillin is the treatment of choice. Treatment of pneumococcal meningitis, which is endemic in many areas, is with penicillin.

Febrile seizures are common in small children and acetaminophen (paracetamol) in either oral suspension or rectal suppositories should be administered to patients on admission.

Yellow Fever and Japanese Encephalitis

Yellow fever (in parts of South America and Africa) and Japanese encephalitis (in parts of Asia) can reach epidemic proportions in specific geographical areas during particular seasons. In areas where either disease is endemic, the appropriate vaccine may be included in the routine EPI or other childhood immunization schedules and heightened surveillance assured during the relevant seasons. At the first signs of an outbreak among the emergency-affected population or in a nearby area, it may be appropriate to give vaccines specific to the local strain on a mass basis.

In all cases, vaccination must be accompanied and preceded by public information efforts to raise awareness of the symptoms and by social mobilization to expedite vaccination and encourage people to seek health care immediately when symptoms are recognized. Vaccination campaigns themselves are organized in a similar manner to that described in Annex 2 for an emergency measles vaccination campaign.
Malaria

Malaria is a major problem in tropical areas, especially during emergencies, when populations from areas of marginal transmission might be moving through or settling in endemic areas.

Malaria kills over 1 million people a year, of which some 750,000 are children under five years of age (Rolling Back Malaria, UNICEF 1999). In sub-Saharan Africa, malaria accounts for one in five of all childhood deaths.

In all cases, the need is for:

• prevention through vector (mosquito) control to reduce transmission and through chemoprophylaxis for pregnant women;
• treatment of individual cases in line with WHO standard guidelines and access to referral centres for severe cases and treatment failures;
• laboratory facilities to diagnose treatment failures and severe disease and, in areas of low transmission, uncomplicated disease.

Vector control measures must be selected according to epidemiological, ecological, social and economic characteristics. Possible measures include:

• personal protection using bednets and curtains, eave strips (strips of cloth covering openings between the roof and walls), screens and other barriers at windows and doors to prevent entry of mosquitoes – all of these impregnated with long−lasting insecticides (this can lower child mortality by about 25 per cent according to WHO); especially young children and pregnant women need to be protected from mosquito bites at all times;
• indoor residual spraying – effective against certain species, but efficacy varies according to house structure and type of sprayable surface;
• larval control and environmental management in areas where breeding sites of mosquitoes are well defined. This involves mobilizing the community to eliminate stagnant water as much as possible and adopting agricultural practices that avoid accumulations of surface water.

In cases of displaced populations, camp sites should be carefully selected, wherever possible. The likelihood of wide−spread malaria is reduced if people live 1 km or more away from the breeding places of anopheles mosquitoes, especially surface water.

Chemoprophylaxis should normally be limited to pregnant women. Exceptionally, more general prophylaxis may be considered for an initial period only for non−immune populations displaced into malarial areas. (More widespread prophylactic use of drugs is not appropriate due to the spread of drug resistance.)

Early diagnosis and prompt treatment will shorten the duration of the disease as well as prevent the development of complications and the majority of deaths from malaria. It should be one of the core functions of primary health care services – and an important component in the (re)training of all health workers – in any area where malaria is endemic.

Drugs should be selected and administered in line with WHO guidelines and established national policy. In many areas, there are high levels of resistance to chloroquine, and treatment with other drugs is recommended. The first step in organizing proper case management for malaria is to acquire the latest information of drug resistance for the specific area (usually from WHO, if not available from the national authorities).

Measles

Measles is common and particularly dangerous in situations where there has been widespread social disruption and large numbers of people are displaced and/or living in crowded conditions, especially if malnutrition is or is likely to become widespread. Vitamin A deficiency is particularly potent as a co−factor in severe measles. In such situations, an emergency measles vaccination campaign is a high priority, as
In the event of an outbreak of measles in a specific population:

- ongoing measles immunization efforts must be accelerated and all children should be vaccinated;
- active supportive treatment must be provided for complications arising from measles which, without proper treatment, can result in death rates of 15–20 per cent or higher;
- the nutritional status of children who develop clinical measles should be closely monitored and adequate feeding be assured even if the child has no appetite.

Treatment should be standardized:

- Vitamin A should be administered immediately to every child with measles: oral doses of 100,000 IU for a child <1 year of age; 200,000 IU for older children. Wherever possible, a second dose should be given the next day (especially if there are eye complications);
- an antibiotic for respiratory complications, e.g. cotrimoxazole for pneumonia;
- oral rehydration therapy for diarrhoea.

If there are eye complications − Bitot’s spots, keratomalacia or corneal ulceration − the first dose of vitamin A should be by intramuscular injection, if possible; antibiotic eye ointments should be applied; and a third dose of vitamin A should be given after 2–3 weeks. These cases should be referred urgently to a hospital.

In all cases, parents (mothers) must be advised of the need to provide adequate food and water – and especially to continue breastfeeding – for sick and recovering children. Measles (and most other childhood illnesses) increase requirements and the practice of withholding food and fluid, traditional in many cultures, can prove lethal.

**Tuberculosis**

Tuberculosis is a chronic, progressively debilitating disease, most commonly involving the lungs and is characterized by fever, cough with phlegm production and weight loss. It can take years to develop after the original exposure and, thus, unlike the diseases discussed above, does not present the threat of an immediate outbreak. It is not rapidly fatal, except in young children, who can die quickly of disseminated TB or TB meningitis. TB is transmitted by airborne bacteria released into the air when an individual who has developed active TB coughs. An estimated 30 per cent of the world’s population is infected with TB, most of whom are concentrated in the developing world.

The crowded living conditions and widespread malnutrition that characterize many emergency–affected populations creates a fertile ground for the rapid transmission of TB in endemic areas. Emergencies also frequently cause interruptions in the treatment regimens of existing cases, reducing the likelihood of an effective cure and increasing the risk of transmission to others and the development of drug resistance. A TB control programme will, therefore, be a priority during an emergency when the prevalence of TB among the population is known to be high.

An existing awareness of the TB problem among the population, resulting from an effective national TB programme prior to the emergency, will greatly facilitate the re–introduction of a systematic treatment programme.

**Strategies for TB Control**

When basic health services are organized and able to meet the daily needs and care of all acute respiratory infections (ARI) or symptoms (asthma) in adults and children, tuberculosis control activities should be developed. Wherever a TB control programme existed before the emergency, it should be re–instated as
quickly as possible. A short-course treatment should be included if it was not practised previously. Priority must be given to achieving a high cure rate rather than to case-finding. The success of TB control effort depends largely on good management and close supervision of patients and health workers.

• BCG vaccination of children

Young children should be protected by a BCG vaccination administered as part of a comprehensive EPI programme, not as a separate TB control activity, excluding children with symptomatic HIV infection. BCG vaccinations should be administered as early as possible in areas of high prevalence. BCG vaccinations protect infants and small children from the more serious forms of childhood tuberculosis such as miliary tuberculosis and tuberculous meningitis. However, BCG vaccinations do not prevent the re-infection and development of other forms of TB. Therefore, the best protection for children is to cure infectious cases in the community with an efficient chemotherapy programme.

• The Stop TB Initiative: Directly Observed Treatment, Short-course (DOTS)

The Stop TB Initiative consists of promoting the use of the cost-effective Directly Observed Treatment, Short-course (DOTS). DOTS is an inexpensive strategy for the detection and treatment of TB. It involves the detection of TB cases through sputum smear tests, followed by 6–8 months of treatment with a combination of drugs. A key component is the regular ongoing support to the patient, including observation to ensure that patients follow the treatment correctly, including follow-up sputum tests to determine whether the treatment has been successful. The strategy can detect and cure the disease in up to 95 per cent of infectious patients, even in the poorest countries (Removing Obstacles to Healthy Development, WHO, 1999).

• The TB and HIV/AIDS: Dynamics of Co-infection

There is reason to believe that the main factor for the resurgence of TB since 1985 is the Immunodeficiency virus (HIV). Co-infection with HIV and TB has serious implications for both diseases and it should always be suspected.

Possible UNICEF Inputs

The expertise and resources of WHO should normally be swiftly mobilized by the government.

For meningitis:

• Vaccines, vaccination supplies, essential drugs.

For yellow fever, polio, Japanese encephalitis:

• Vaccines, vaccination supplies.

For malaria:

• Impregnated bed nets.
• Drugs.
• Support to appropriate vector control measures.

For measles:

• Vitamin A supplements.
• Vaccines; ORS and cotrimoxazole.

Plus, in most epidemics:

• Support for special training for health workers.
• Support for in-country transport and distribution of priority supplies and personnel (transport may be temporarily diverted from other programme purposes).
• Social mobilization and specifically focused health education programmes among the most vulnerable communities.

• Where specific epidemics are common, provision to respond to the predictable needs for assistance should be included in the regular UNICEF health programme budget and recourse be made to ‘emergency’ assistance processes only if the epidemic takes on unusually major proportions or generates extraordinary needs.

For tuberculosis:

• BCG vaccine in the context of EPI.

Further Guidance


Centre for Disease Control (CDC), *Famine–Affected, Refugee and Displaced Populations: Recommendations for Public Health Issues.*, MMWR, Atlanta, July 1992


Chapter 1 – Annex 8: Protecting Pregnancy in Emergencies

Objective

To reduce maternal and neonatal mortality and morbidity in emergencies through timely and appropriate safe motherhood interventions.

Priorities and Strategies

Assuring adequate reproductive health care is a critical but often overlooked priority in emergencies. The family and community breakdown, increased incidence of rape and other forms of gender–based violence, higher rates of malnutrition and disease and the disruption of health services that accompany many complex emergencies all place women’s reproductive health at particular risk and create an urgent need for basic
Emergency Phase Safe Pregnancy Services should Include:

- At the onset of an emergency, appoint a reproductive health or maternity care specialist responsible for the assessment and the establishment of a safe motherhood services plan and the selection of key indicators for monitoring service delivery.

- As soon as feasible, organize comprehensive services for antenatal, delivery and postpartum care. Planning for such services should take into account existing facilities for the local population. Refugee, displaced and local populations should all be considered when planning services, which should also include obstetric and medical emergencies.

- To ensure that services are appropriate to the emergency, it is essential to:
  - Identify skilled care providers involved in childbirth (physicians, midwives, nurses and TBAs);
  - provide training, as needed;
  - ensure that all refugee women and their families know where to obtain assistance for antenatal care and delivery and how to recognize signs of complications in pregnancy and in labour.

- Ensure that safe motherhood programmes include the input of beneficiaries and providers and reflect a balance between modern and traditional attitudes and practices. The input of women in particular should be sought on the planning and provision of care, starting in the initial phase of the emergency.

- Preventive measures to guard against HIV transmission between patients and providers should be taken and special attention paid to mother to child transmission (MTCT). (Please see Annex 9 for further information on MTCT.)

- Provide Home Delivery Kits to all pregnant women.

- Establish an obstetric facility equipped with material and personnel for essential delivery care. Services can be provided in the general health clinics or in a mobile clinic during an ongoing migration until specific obstetrical facilities are established. The UNICEF Basic Emergency Obstetric Care Kit can be used to equip obstetrical facilities.

- Women of childbearing age should be vaccinated against tetanus, especially in situations where sanitary conditions are poor or the majority of deliveries are without medical or midwifery support.

- Develop a referral system for women with complications requiring surgical intervention to the nearest facility where emergency obstetric care can be provided. Often, local health centres and hospitals will need upgrading or specific resource support to handle the increased caseload. Around−the−clock transport should be arranged to handle referrals to health centres and nearby hospitals.

- Provide medical care, including prophylactic therapy for STDs, for female survivors of rape and other forms of sexual violence. Counselling should also be provided. (Chapter 11 focuses specifically on sexual violence).

Antenatal Care

The main objective of antenatal care in an emergency situation is to establish contact with the women and identify and manage current and potential risks and problems.
A minimum of three visits throughout pregnancy is recommended. The following is a basic framework for action during these visits:

- develop a home delivery system, encompassing the provision of birth kits, referral for women with complications and simple record keeping of the number of births and deaths;

- plan the place of delivery and the type of assistance at delivery, based on obstetric history and pregnancy complications. The following risk factors are commonly used: height, weight, age, number of previous deliveries, bleeding, high blood pressure, STDs, malnutrition, severe anaemia and the use of antenatal care;

- identify, counsel and refer women with potential pregnancy complications;

- ensure that every pregnant woman has received a delivery kit;

- observe and record clinical signs, including blood pressure, height, fetal heart rate, uterine growth and anaemia;

- test blood for STDs and HIV;

- dispense medications, as appropriate, including iron folate prophylaxis, tetanus toxoid immunization (a minimum of 2 doses per woman is recommended), antimalarials, anti-helminthics (hookworm) and supplementary food rations (a balanced diet of 2,000–2,500 calories/day is required);

- promote exclusive breastfeeding and vaccination;

- provide emergency care for ante-partum haemorrhage, premature delivery, pre-eclampsia and eclampsia;

- develop with each woman a referral plan for unforeseeable complications.

Delivery Care

Skilled assistance is essential to delivery care. Complications should be treated either at health centres or district hospitals, depending on the level of care required. For deliveries at home by trained midwives, TBAs or family members, a simple system of supervision needs to be devised. In the case of delivery complications, the woman must be transferred to the nearest health facility or hospital.

For deliveries in health centres, standard protocols should be used for the surveillance and the management of labour: initial assessment, duration, use of simplified partograph, assessment of fetal well-being, urinary catheterization, episiotomy, breech delivery, multiple births, indications for caesarean section, as well as management of post-partum haemorrhage and retained placenta.

Essential obstetric care at the level of health centres should also include:

- the use of broad spectrum antibiotics: oral, IM or IV (not tetracyclines);
- management of severe pre-eclampsia and eclampsia: anticonvulsants and low forceps;
- repair of vaginal tears;
- manual removal of placemtas;
- management of haemorrhages: oxytocics or ergometrine; and
- management of shock and pre-transfer stabilization: IV plasma expanders.

Care must be taken to avoid overwhelming health facilities with the demands of refugees and displaced to the detriment of local people.

A complete range of emergency obstetric services should be available at the hospital level, including caesarean section, laparotomy, hysterectomy, repair of cervical and third-degree vaginal tears, as well as safe blood transfusion.
Post-Partum Care

Since up to 50 per cent of maternal deaths occur after delivery, a midwife or health worker should visit the mother within the first 24–48 hours after birth (Reproductive Health in Refugee Situations, An inter-agency Field Manual, 1999, United Nations High Commissioner for Refugees).

During the visit, issues of cleanliness and newborn care should be covered. Actions required during the visit should include:

- assessment of the mother’s and the child’s general condition and referral for complications such as haemorrhage, sepsis, perineal trauma, breast abscesses, newborn prematurity or failure to thrive;
- identification of any special needs, particularly if the mother is alone as head of the family;
- support for early and exclusive breastfeeding;
- discussion of maternal diet and provision of supplementary rations (up to 2,500–3,000 calories/day), if required;
- provision of iron folate tablets and vitamin A.

Monitoring

Data on both mortality and morbidity should be collected during the emergency and analysed by a qualified epidemiologist.

Every maternal death should be investigated to determine the cause and to ensure that the referral system is responding appropriately to obstetric emergencies.

Possible UNICEF Inputs

Depending on the needs assessment and the complementary capacities of UNICEF and its partners, some of the following inputs could be considered:

- provision of UNICEF Basic Emergency Obstetric Care and Home Delivery Kits;
- funding for training and assessment activities;
- provision of counselling, especially to victims of sexual violence.

Further Guidance


UNHCR, Field Manual on Reproductive Health in Refugee Situations, October 1995

UNHCR, Reproductive Health in Refugee Situations. An inter-agency Field Manual, 1999

WHO/UNICEF/UNFPA, Joint Statement on Traditional Birth Attendants, 1992

WHO, The Mother Baby Package, 1994

Panel

Panel 1 – Checklist for Safe Motherhood Services in the Emergency Phase

<table>
<thead>
<tr>
<th>Checklist for Safe Motherhood Services in the Emergency Phase¹</th>
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<tr>
<td>• provision of delivery kits;</td>
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<td>• identification of referral system for obstetric emergencies:</td>
</tr>
<tr>
<td>1. one health centre for every 30,000 to 40,000 people;</td>
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<tr>
<td>2. one operating theatre and staff for every 150,000 to 200,000 people;</td>
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<tr>
<td>3. skilled health care providers trained and functioning (one midwife for 20,000 to 30,000 people, one TBA for 2,000 to 3,000 people);</td>
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<td>4. community beliefs and practices are known;</td>
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<td>5. refugee and displaced women are aware of services availability.</td>
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¹ The information contained in this checklist will be assessed during the upcoming Monitoring and Evaluation Review.

Chapter 1 – Annex 9: Prevention and Treatment of STDs/HIV/AIDS

Objectives

To reduce the transmission of sexually transmitted diseases (STDs), including the human immunodeficiency virus (HIV), especially among young people and to provide the best care possible to affected individuals, families and communities.

UN Inter–Agency approach to HIV/AIDS in Emergencies

HIV spreads fastest during complex emergencies when conditions such as poverty, social instability and violence against women are most extreme. In addition, psychosocial stress resulting from insecurity can cause coping mechanisms of individuals and communities to deteriorate. This can result in high–risk sexual behaviour and can render individuals powerless against sexual abuse. Moreover, in situations of war and civil strife, programmes and services intended to control HIV/AIDS tend to be disrupted or break down, making the population even more vulnerable.

The Sub–Saharan African region is the most heavily hit by the HIV/AIDS pandemic: it accounts for almost 70 per cent of the total global number of HIV–positive people and 83 per cent of cumulative AIDS deaths, despite the fact that the region contains only 10 per cent of the world’s population. Currently, 23.3 million people are living with HIV/AIDS in Sub–Saharan Africa, of which 12.2 million are women. In 1999, nearly 90 per cent of infants who acquired the virus perinatally or through breastfeeding were African. (UNAIDS, December1999).

In recent decades, Africa has experienced a growing number of complex emergencies, in countries such as Angola, Rwanda, Burundi, the Democratic Republic of Congo, Liberia, Uganda, Ethiopia, Somalia and Sierra Leone, where the presence of HIV is known to be high.
The spread of HIV is accelerated by war. Awareness of the risk of HIV/AIDS in soldiers (both national armies and international peacekeepers) is limited; yet, soldiers are a high-risk group. In addition, soldiers often leave their partners in poor economic situations, often leading to prostitution.

In war, women and children are at a heightened risk of violence, including rape. In some conflicts, rape is used as a method of intimidation and persecution. Women and girls are most vulnerable to sexual abuse; this is heightened during displacement.

Data reveal an increased level of HIV risk in refugee and displaced populations. Displacement plays a role in the spread of the HIV infection, and it is often associated with the disruption of existing social structures and relationships. Evidence also indicates that children become sexually active at an earlier age when displaced.

Forced migration from rural areas to heavily populated areas at the periphery of towns, the use of unsterilized needles, contaminated blood transfusions and the handling of injections by unqualified persons can increase the risk of transmission during civil strife.

Specific Strategies for UN Action

The Inter-Agency Sub-Working Group on HIV/AIDS (representing WHO, UNAIDS, UNHCR, UNICEF, FAO, ICRC, IFRC, IOM, OCHA, UNFPA and MSF) has decided on the following strategies for UN action.

• Further studies on how to integrate the UN’s approach to HIV/AIDS into the broader agenda of conflict prevention should be carried out. The UN family, therefore, must look at war and civil strife as a cause and a consequence of the spread of HIV.

• HIV/AIDS is a problem that requires a multi-sectoral approach, especially in complex emergencies. Health, poverty, human rights and legal issues, forced migration and refugees, security, military forces, and violence against women are only some of the priority sectors related to the transmission of HIV that must be considered in any intervention that seeks to have an impact.

• Governments must be reassured, particularly those hosting refugees, that the international community is aware of the extra burden imposed upon them and that it will do whatever is possible to help shoulder the responsibility. Regarding HIV/AIDS, this requires ensuring that interventions planned by local and international entities are in line with the national programmes. In countries where HIV control programmes are less effective, assistance to strengthen national policies and strategies for HIV/AIDS is a priority.

• In the context of forced migration, it should be recognised that there is considerable interaction between communities, and that providing services for one and not for the other can be counterproductive, weakening the impact of the intervention. Also, equity would be severely jeopardised by uneven distribution of interventions. In other words, every effort should be made to provide the same services for refugees/displaced persons and the surrounding population. Thus, governments and agencies, according to their respective mandates, should make sure that both populations are evenly attended through a coordinated and comprehensive approach.

• Specific vulnerable groups (refugees, IDPs, humanitarian workers, peacekeepers, soldiers, sex workers, etc.) should be identified and their needs assessed. When targeting a certain vulnerable group, however, enhancing the stigma associated with certain pathologies characteristic to the group should be avoided. This is certainly more important in the case of the HIV/AIDS infection where social exclusion is likely to occur.

• Building on already existing resource tools, it might be useful to consider two different “standardised basic packages for HIV/AIDS in countries with complex emergencies,” according to at least two different situations of the crisis cycle. The first would be implemented during the acute stage of the crisis when chaos leads to the breakdown of the political, social and/or physical infrastructure. The second package would cover pre- and post-crisis situations where a certain degree of stability exists and/or the rehabilitation phase has commenced. It would be advisable to mainstream and identify essential components for
such strategies.

Below are a number of items for HIV/AIDS packages that still require integration among themselves:

• Identification and assessment of needs. Vulnerability assessment concerning HIV/AIDS should be developed by all relevant agencies working in complex emergencies (guidelines to be revised and ‘translated’ according to specific contexts).

• Distribution of information and other promotional activities will help increase awareness among the population and UN and NGO staff on issues related to HIV/AIDS in complex emergencies. This should include the elaboration of information and training packages on HIV prevention as well as material concerning high-risk behaviour such as unsafe sex. Condoms should also be provided.

• Early detection of sexually transmitted infections (STI) and possible AIDS cases should be put in place and, as laboratory services for confirmation might not be available, existing national ‘syndromic’ management guidelines for health workers should be elaborated or updated and applied (guidelines for health workers).

• Organisation of emergency response units and emergency reproductive health services that incorporate the Minimum Initial Service Package (MISP\textsuperscript{1}).

\textsuperscript{1} Reproductive Health in Refugee Situations and Inter−Agency Field Manual (1999) UNHCR. Components of the MISP are: (1) identify an organization(s) and individual(s) to facilitate the coordination and implementation of the MISP; (2) prevent and manage the consequences of sexual violence; (3) reduce HIV transmission; (4) prevent access, neo−natal, maternal, morbidity and mortality; (5) plan for the provision of comprehensive LHRH services, integrating into primary health care, as soon as possible.

• Development or strengthening of the health delivery services (health facilities, training of staff, drugs and medical supplies, laboratory services, etc.) to ensure quality HIV care to the displaced populations.

• Work with adolescents and children to reinforce self−esteem, thus enhancing the positive role that young people can play in promoting positive values and healthy lifestyles in complex emergencies. The promotion of safe sexual behaviour needs to be included into the educational curricula.

• Provision of medical protection\textsuperscript{2}, for people who have been sexually assaulted, including humanitarian workers. A clear policy must be implemented in all health care facilities to ensure that health care workers are protected from the risk of exposure to HIV/AIDS.

\textsuperscript{2} Kits with contraception and anti retroviral treatments together with other specific strategies might be considered as an integral component of HIV prevention programmes in complex emergencies.

• Strengthening of local organisations in high−prevalence areas to provide appropriate assistance to HIV/AIDS affected households and communities with a view to protect and promote sustainable livelihoods. Social support to patients and families, including food and other basic items, will decrease their vulnerability and the need to sell sex for food, shelter and security.

• HIV−free blood supply and test−kits for safe blood programmes.

• Mainstreaming of HIV/AIDS considerations into humanitarian and rehabilitation projects and programmes in complex emergencies.

• Coordination, networking, community mobilisation and planning instruction in the field (with national authorities, specialised agencies, NGOs, etc). It is necessary to help all partners, including NGOs and other social subjects of civil society, network among themselves and address the problem with a holistic approach.
Individuals from the affected population are to be identified and involved in conducting and expanding educational activities among refugees and displaced people. The existing “Guidelines for HIV Interventions in Emergency Settings” elaborated by WHO, UNHCR and UNAIDS Joint United Nations Programme on HIV/AIDS are an important resource and must be disseminated and implemented in the field. Capacity building programmes are imperative for the implementation of the guidelines.

In addition to the above strategies, the following points require attention:

- Programmes should provide psychosocial services for the affected population, with particular focus on vulnerable groups and women, children and youth who have been the victims of sexual abuse. Counseling should also focus on preventive measures and safe behaviour.

- Security in the camps or among displaced communities is critical to the safety and well-being of the affected population. The local community and leaders within displaced communities should be involved in the care of the beneficiaries.

**UNICEF’s Role within the UNAIDS Programme**

UNICEF is the chief advocate for children, women and families within UNAIDS. Within the broader UNAIDS approach, UNICEF focuses on the following priority programme areas:

- Prevention of mother to child transmission
- Young people’s health and development
- Children and families affected by HIV/AIDS
- AIDS education
- Breaking the silence on HIV/AIDS

While in emergencies we should strive to focus on all five of the priority programmes above, at the onset of an emergency it is often only possible to provide limited support.

**Prevention of Mother to Child Transmission (MTCT)**

UNICEF is working to ensure that women have access to voluntary and confidential HIV testing and counselling and to interventions (antiretroviral drugs, counselling on infant feeding and alternatives to breastfeeding, where they choose not to breastfeed) to reduce the risk of transmission to their infants for those women who are HIV positive.

In developing countries, the probability that the infant of an HIV–infected mother will be infected ranges from 25 to 44 per cent. The additional risk of MTCT through breastfeeding is estimated to be 10 to 20 per cent in populations where HIV–positive pregnant women have received no intervention and breastfeeding together with other food and fluids continue through 24 months. Most areas of high HIV prevalence are in parts of the world where not to breastfeed results in infection and death. The risk of death is highest in the early months. For example, in one study exclusive breastfeeding was shown to have a significant lower risk than mixed feeding, which includes breastfeeding and other foods and fluids, and an equal MTCT rate with exclusive formula feeding up to 6 months. In unstable situations, replacement feeding – the process of feeding a child who is not receiving any breastmilk with a diet that provides the primary nutrients needed by a child – carries an even higher risk.

It is important to note that women who know that they are HIV–infected have the right to know the risk of MTCT through breastfeeding and the right to know about all infant feeding options. They need support and guidance through infant feeding counselling to make the decision that is best for their circumstances. Therefore, counselling on alternatives to breastfeeding should take into account the feasibility, affordability, safety and sustainability of replacement feeding. (refer to Nutrition chapter’s annex on infant–feeding)

In view of the availability of effective interventions and UNICEF’s involvement with mother and child health and nutrition, as well as its global leadership role in promotion, protection and support of breastfeeding, prevention of mother to child transmission is a UNICEF priority programme area.
During an emergency situation, displaced and other affected communities should have access to testing services for STDs and HIV. Psychosocial services should also be provided to those who test positive to HIV.

**Young People’s Health and Development**

UNICEF’s young people’s health and development programming aims at:

- Providing young people with the knowledge and skills to protect themselves from HIV and other STDs.
- Encouraging changes in policy and service delivery to ensure that young people have access to youth-friendly health and social services.
- Promoting safe and supportive environments that enable young people to choose safe and healthy behaviour.
- Advocating for young people’s rights and addressing the sexual exploitation of youth.
- Involving young people, including those with HIV, in research to identify needs and in the design and implementation of programmes to address these needs.

During a crisis, focus should be on access to testing services, psychosocial counseling and access to user-friendly services.

**Children and Families Affected by HIV/AIDS**

UNICEF is focusing on approaches that enable AIDS orphans to remain within the community as well as on approaches that strengthen families’ capacity to cope and that experiment with alternative models of care. Programmes focus on monitoring the impact of HIV/AIDS on children, identifying vulnerable children and improving orphan registration schemes, ensuring that children and families have access to essential health and social services and supporting the efforts of local organizations to provide practical support to orphans and their families.

UNICEF’s current programming for children and families affected by HIV/AIDS emphasizes:

- Working with UNAIDS and with community partners such as NGOs, churches and child-oriented organizations to increase awareness of the needs of children and mobilize action for children and families affected by the epidemic.
- Advocacy to promote children’s rights to health, education, inheritance and protection from abuse, sexual exploitation and discrimination.
- Supporting the development of effective community-based approaches to assist children and families affected by HIV/AIDS.
- Ensuring that essential health care and nutrition services – immunization, prevention and treatment of common childhood diseases – reach children and families affected by HIV/AIDS.
- Preventing HIV infection in women, especially younger women and adolescent girls.

During an emergency, children with HIV/AIDS or AIDS orphans are even more vulnerable. UNICEF’s leadership in the area of unaccompanied minors in countries in conflict represents a strong base for the care of AIDS orphans.
AIDS Education

UNICEF supports the development of life skills and health education curricula, training of teachers and production of advocacy materials.

Schools have the potential of reaching large numbers of children and are crucial settings for learning about HIV/AIDS prevention. School-based initiatives are a priority, but informal schooling and information on HIV/AIDS may also be appropriate during a crisis.

UNICEF’s AIDS education programme emphasizes:

- Developing life skills to enable children to make healthy choices and adopt safer behaviours.
- Promoting the rights of children with HIV/AIDS and children from families affected by HIV/AIDS to education and a safe non-discriminatory school environment.
- Protecting the rights of pregnant school girls to education.

Exposure to life skills education, before the onset of sexual activity, can encourage responsible, safe behaviour. The available evidence clearly shows that effective sex education does not lead to or encourage sexual activity and can, in fact, delay the age of the first intercourse and protect sexually active young people from unwanted pregnancy, HIV and STDs. Consequently, most UNICEF-supported school-based programmes have focused on life skills education, providing support for curriculum development and teacher training and production of educational materials.

During crises, educational facilities might have been destroyed or displaced populations might not have access to schools. However, teachers within the displaced communities could be a valuable resource for forming informal education groups in the camps. Informal education should focus also on health issues, including HIV/AIDS education, safe behaviour, and coping mechanisms during an emergency. Psychosocial counselling should be integrated in the programme, as well as games, role playing and conflict resolution skills.

Involvement of community leaders, religious leaders and teachers is key to the success of any programme of informal education, especially to ensure that it is sustainable and to provide continuity once the displaced return to their areas of origin.

Breaking the Silence on HIV/AIDS

UNICEF views communication as a critical tool for strengthening HIV/AIDS prevention and care, tackling stigma and discrimination and addressing the social and cultural norms that influence sexual behaviour.

At the global level, UNICEF is advocating for children’s rights and breaking the “conspiracy of silence” that exists about HIV/AIDS. At the field level, UNICEF has worked to increase awareness and reporting on HIV/AIDS issues among the news media and has used radio and television drama, soap operas, popular dance, and music to communicate HIV/AIDS messages.

During a crisis, it is important to provide testing, counselling and a safe and secure environment for the displaced or affected population. Voluntary and confidential testing should be made available, as well as psychosocial counselling and information materials on HIV/AIDS and safe behaviours.

HIV Testing and Treatment

Testing for HIV should be provided to the affected population on a voluntary basis. Care and special counselling for HIV-positive individuals is also essential. Care for people with HIV-related illnesses – e.g. diarrhoea, respiratory infections, etc. – is a component of basic curative care in an emergency. This is especially important when the emergency population is in, or comes from, an area where HIV-related illnesses are widespread.
Treatment should include promotion of good hygiene practices and help the patient maintain a nutritious diet, if possible. Education of patients and their families is vital to prevent the spread of HIV infection. Psychosocial counselling will help reduce stress and anxiety. Pregnant women who are HIV positive should be informed about MTCT and ways to prevent it.

Health Services Precautions Against HIV Transmission

The precautions listed in Panel 1 are essential to prevent the transmission of HIV from patient to patient, health worker to patient and patient to health worker. All emergency workers – not just health workers – must be fully aware of the risks and the precautions. Blood handling precautions are particularly important. HIV and other infections, including syphilis and hepatitis B, can be transmitted through blood transfusions; and from the inception of an emergency, all blood should be assumed to be infectious. Clear guidelines concerning blood transfusions should be issued to all health units and blood transfusion services must be provided with the necessary reagents and consumables for the collection, screening and storage of blood.

Health Services for the Testing and Treatment of STDs

While HIV requires particular attention, other sexually transmitted diseases (STDs) need to be monitored during an emergency, as they also can have an impact on the well-being of the population. As is the case for HIV, STDs also spread fastest during complex emergencies when conditions such as social instability and violence against women are most extreme.

All the preventive activities focusing on HIV are equally valid for all other STDs.

While the diagnosis and treatment of STDs should be part of the essential services provided to the population, it is important to keep in mind the sensitivity of the issue and the need for adequate counselling and education of the patient.

Treating the sexual partners of individuals affected by STDs is vital and especially important for women, who are less ready to seek treatment than their partners. As women are often asymptomatic for STDs, they should be asked during all medical consultations whether they have experienced any unusual vaginal discharge or lower abdominal pain. UNICEF should look at WHO and UNFPA to take the lead in this area, but it can provide support in the form of provision of drugs, especially for treating gonococcal ophthalmia (see Panel 2) and simple tests for syphilis in pregnant women.

Syphilis in a pregnant woman is dangerous for the woman and her child. Screening all pregnant women for syphilis should be a part of routine antenatal care. Easy-to-use syphilis test kits are required. If such systematic screening is not possible but there is known to be a high prevalence of syphilis in the population, the prophylactic treatment of all pregnant women with a single injection of bezathine penicillin at the first antenatal contact may be a justified alternative.

Women who have been raped should be given immediate prophylactic therapy for gonorrhoea, chlamydia and syphilis and should be offered post-coital contraception and given psychosocial counselling. (Please see Chapter 11 on ‘Sexual Violence’).

Further Guidance


UNAIDS, AIDS Epidemic Update, December 1999

UNHCR, Reproductive Health in Refugee Situations and Inter-Agency Field Manual, 1999

67
WHO/GPA, Collection, Testing and Transfusion of 200 units of Whole Blood, example of a checklist of essential items, 1994

WHO, Management of Sexually Transmitted Diseases (WHO/94.1), 1994

WHO/GPA, Recommendations on HIV/AIDS/STD (for Rwanda), 1994

Recent UNICEF tools developed at UNICEF Headquarters:

Action plan for programming to reduce vertical transmission of HIV (CF/PD/PRO 1997/009)

Update on implementing the WHO, UNICEF, UNAIDS policy guidelines on HIV and infant feeding (CF/PD/PRO/99–005)

Update on prevention of MTCT (CF/PD/PRO/99–006)

Country specific guides produced by field offices

Panels

Panel 1 – Health Services Precautions against HIV Transmission

<table>
<thead>
<tr>
<th>HEALTH SERVICES PRECAUTIONS AGAINST HIV TRANSMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Frequent hand washing with soap.</td>
</tr>
<tr>
<td>• Wearing gloves and other protective clothing – e.g. masks, eye guards and gowns – to prevent direct contact with blood, wounds, bodily fluids and corpses.</td>
</tr>
<tr>
<td>• Safe handling and appropriate disposal of waste materials, particularly ‘sharps’ (needles, scalpels, etc.), in puncture–resistant containers.</td>
</tr>
<tr>
<td>• Thorough sterilization or disinfection of medical instruments.</td>
</tr>
<tr>
<td>• The undertaking of blood transfusion safety measures:</td>
</tr>
<tr>
<td>• Transfuse blood only in life–threatening circumstances and when no other alternative is possible.</td>
</tr>
<tr>
<td>• Use blood substitutes (crystalloids/colloids) whenever possible.</td>
</tr>
<tr>
<td>• Test blood using appropriate, simple and rapid–assays for HIV (and syphilis and hepatitis B when possible) before transfusion.</td>
</tr>
<tr>
<td>• Select low–risk donors wherever possible, e.g. those with no history of STD; those from areas of low HIV prevalence; those with an absence of symptoms and signs of HIV infection or other illnesses.</td>
</tr>
</tbody>
</table>

Panel 2 – Prevention and Treatment of STDs and Related Diseases in Children

<table>
<thead>
<tr>
<th>PREVENTION AND TREATMENT OF STDs AND RELATED DISEASES IN CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonococcal ophthalmia can cause infants to go blind within three days if the condition is not treated. The infection in newborn babies can be prevented by timely eye prophylaxis: At the time of delivery, a newborn’s</td>
</tr>
</tbody>
</table>
eyes should be carefully cleaned and treated with a 1% silver nitrate solution or 1% tetracycline ointment. Mothers should be told to take their infants to a clinic immediately if they see any signs of eye discharge within two weeks of birth.

Sexually abused children: Give a child known to have been sexually assaulted or abused a low-dosage prophylactic treatment for presumptive gonorrhoea, chlamydia and syphilis. This is particularly important in an emergency situation when regular follow-up may not be possible.

Chapter 1 – Annex 10: Health Monitoring and Surveillance

Objectives

• To re-establish health monitoring and information systems to provide a basis for planning, adapting and managing health service provision during an emergency and on a longer-term basis.

• To ensure reporting systems and epidemiological surveillance to detect any signs of particular health problems and enable early action to be taken to contain any outbreak of communicable diseases.

Methods and Principles

Reports from health facilities and medical teams must be received, analysed and evaluated regularly by the responsible authorities. Any reports of specific outbreaks of disease must be rapidly investigated. Sample surveys may be undertaken to determine the prevalence of particular conditions. Note that clinic attendance rates and the incidence of symptoms and diseases observed are not necessarily representative of the health situation in the community as a whole. The appearance of new diseases or sudden changes in the observed rate of incidence are, however, often significant.

The restoration and reinforcement of pre-existing reporting and surveillance systems is a high priority in any emergency. A thorough understanding of how those systems operated previously is essential.

In the absence of any effective and pre-existing arrangements – and especially if laboratory facilities are lacking and diagnostic criteria are not standardized:

• request regular reports from all health posts and medical teams on the occurrence of a limited number of symptom complexes that are suggestive of specific diseases (a) likely to arise in the particular circumstances, (b) amenable to control measures;

• do not try to establish a sophisticated system from scratch.

This minimizes the administrative demands on hard-pressed medical workers, while providing enough information to prompt more specific investigations by epidemiological personnel when particular symptoms become prevalent.

The sample report form is provided in Panel 1. Such a report might be integrated with summary reports of nutrition status data and special (supplementary and therapeutic) feeding operations.

The central surveillance unit should:

• present the appropriate decision makers with a summary of the data, conclusions and specific recommendations for action;

• feed-back summary data and conclusions to all reporting units.
In all situations, reports and information from informal sources should also be taken note of and be investigated to reassure the population by defusing any unjustified rumours or by taking action when the information is confirmed.

**Practical Considerations**

All health workers and medical teams must understand the importance of surveillance and therefore of submitting their own reports regularly – including zero returns when necessary, rather than no report.

Give clear guidelines to health workers at each location on how, when and to whom to send their reports. The schedule and deadlines established for the submission of reports must be enforced. Telephone, telex or radio may be used where available. Otherwise, reports may be sent by hand of previously identified personnel (e.g. those involved in food distribution) who are touring.

Ensure clear guidelines on who has the responsibility to respond to epidemiological reports.

Ensure staffing of the central epidemiological unit by appropriately trained and experienced national epidemiologists. Mobilize international assistance where needed to expedite the establishment of an appropriate system.

The epidemiological unit must have ready access to transport and laboratory facilities (possibly including WHO collaborating centres) in order to be able to respond promptly to any indications of disease outbreaks and to obtain definitive diagnoses. Medical personnel specifically assigned to surveying and surveillance functions should, if at all possible, be able to refer cases requiring treatment to others and not be required to take responsibility for individual patients.

**Possible UNICEF Inputs**

Depending on the assessment of actual needs and possibilities, some of the following inputs could be considered:

- financing of expert epidemiological services (only if WHO, the Red Cross or other medical assistance agencies are not able to do so);
- training of health staff;
- transport;
- laboratory equipment and supplies;
- office supplies and local operating costs.

**Further Guidance**


Chapter 2: Supporting Nutritional Needs

Rationale

Malnutrition is an important contributor to child morbidity and mortality in both emergency and non-emergency situations. Its prevention and treatment must be a top priority in all circumstances. Malnutrition weakens children’s ability to resist common childhood infectious diseases, and the course and outcome of these diseases are more severe and often more fatal in malnourished children. Malnutrition also has a negative impact on children’s cognitive development.

Emergencies frequently result in dramatically increased rates of malnutrition. In Somalia in 1993 and Liberia in 1995, for instance, more than 50 percent of children in some regions were suffering from moderate or severe malnutrition. During the 1983 famine in southern Sudan, the prevalence of acute malnutrition (wasting) reached an unprecedented level of 65 percent. Nearly a quarter of a million refugee children in 1990 were estimated to be suffering from acute malnutrition.

Basic Principles

### General Aims

- To prevent famine-related deaths and malnutrition;
- To reduce malnutrition and protect the nutritional status of the most vulnerable groups, which include young children and pregnant and lactating women;
- To promote sustainable, self-reliant means of livelihood and household food security as quickly as possible;
- To restore/provide access to health, water supply, education and other basic services for all; and
- To reduce vulnerability and increase capacity to cope with and recover from future crises.

Emergency nutrition programmes should be directed towards ensuring the right to nutrition and freedom from hunger as set forth in the following international human rights covenants:

- Freedom from hunger and malnutrition was declared a basic human right in the 1948 Universal Declaration of Human Rights: “Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food...” (art. 25, para. 1).

This human right was reiterated in the International Covenant on Economic, Social and Cultural Rights (art. 11), which entered into force in May 1978.

- In 1996, all States that participated in the United Nations World Food Conference reemphasized the right to be free from hunger and malnutrition: “Every man, woman and child has the inalienable right to be free from hunger and malnutrition in order to develop fully and maintain their physical and mental faculties.”

- The elimination of hunger and malnutrition was one of the six goals of the Third United Nations Development Decade, as well as a goal of the WHO Declaration on ‘Health for All by the Year 2000’.

- Children are the primary victims of malnutrition. Their right to adequate nutrition is enshrined

Causes and Forms of Malnutrition

A conceptual framework for understanding malnutrition

The following conceptual framework illustrates the levels of causality for malnutrition and death. Malnutrition in children or adults on an immediate level, results from the combined effects of poor dietary intake, illness, and trauma or abuse. These are the product of an underlying level of causes including:

- access to food by households (or by individuals if households are not intact);
- access to basic health services and a healthy environment;
- capacity to offer care and protection to children and their caregivers.

**Article 24 of the CRC** recognizes the right of the child to the enjoyment of the highest attainable standard of health, and commits States Parties, in implementation of this right, to take all appropriate measures to combat disease and malnutrition, through provision of adequate nutritious foods and clean drinking water.
Causes of Child Malnutrition

These underlying causes are in turn determined by a range of basic causes such as:

- political and economic structures;
- culture and ideology;
- the use and control of human, institutional and economic resources.

The framework shows how emergency situations may increase the risk of malnutrition and mortality by disrupting societal functioning at all levels. It demonstrates the importance of understanding the relationship between the various immediate, underlying and basic factors leading to malnutrition and mortality in a given situation. It also points to the relationships among various sectoral interventions that may be taken in an emergency situation. The framework highlights that in emergency situations as well as at other times, ensuring adequate food does not guarantee good nutrition.

Inadequate primary health care services and control programmes for common childhood infectious diseases, such as diarrhoea, measles, and acute respiratory infection, reinforce this circle of infection and malnutrition. Hazards such as unsafe excreta disposal, or inadequate or contaminated water supplies, increase the risk and aggravate the link between malnutrition and infection.
Underlying causes of malnutrition

As illustrated in the conceptual framework, malnutrition is the product of three major underlying factors – food, health and care. These underlying causes are linked in many ways, but perhaps most importantly by the capacity of women and other principal caregivers to devote time and resources to these basic needs. Each is discussed briefly below.

Access to food

It is at the household level that most people gain access to food. Households have access to food through their own production of food, exchanging their labour or money for food, being part of family or social networks that have access to food, or food aid. All of these means of access may break down in an emergency, and households themselves may not be intact. Even when food may be available, people may not have the means to prepare it or it may be unacceptable to them.

The vicious circle of disease and malnutrition in children is well documented:

- infectious disease impedes dietary intake and nutrient absorption;
- this leads to malnutrition;
- malnutrition renders a child unable to resist common childhood infectious diseases.

Care

Care factors most directly related to nutrition, which may be disrupted in an emergency, include:

- infant feeding practices (i.e. breastfeeding practices, use of breastmilk substitutes);
- complementary feeding practices;
- feeding practices during illness, food hygiene, etc.;

Equally important are factors less directly linked to nutrition, including:

- the degree to which a child is protected from trauma and abuse;
- the affection and physical stimulation received by the child;
- the status and support given to caregivers.

It is not only the caregiver’s knowledge of care and feeding practices that determines the quality of those practices, but also whether the caregiver is healthy, protected from trauma and abuse, self−confident, able to spend sufficient time providing care, and surrounded by affection and support. Even in emergencies, it is futile to focus on improved infant feeding without appropriate attention, protection and support to caregivers, especially women.

Health services and a healthy environment

Inadequate primary health care services and control programmes for common childhood infectious diseases such as diarrhoea, measles and acute respiratory infection, reinforces the circle of infection and malnutrition. Hazards such as unsafe excreta disposal, or inadequate or contaminated water supplies, increase the risk and aggravates the link between malnutrition and infection.

Forms of Malnutrition

Malnutrition can be of two different forms:

- protein−energy malnutrition
- vitamin and mineral deficiencies.

Malnutrition occurs when energy and nutrient needs – as determined by age, gender, ambient temperature, body size, growth, health status, physical activity and other factors – exceed dietary intake or absorption.

Protein−energy malnutrition (PEM):
In most cases PEM affects children between six months and five years of age, and is a particular threat when breastfeeding has stopped. It can manifest itself in a number of ways:

- Nutritional marasmus, involving weight loss and the child becoming very thin; in extreme cases skin appears to hang loosely from the bones and the eyes become sunken.

- Kwashiorkor, for which the main sign is oedema, i.e. the swelling of the feet and lower legs, which may extend in advanced cases to the arms and face. Hair also becomes lighter in colour and may fall out easily.

- Marasmic kwashiorkor is a common symptom of these two conditions, i.e. the child appears thin and wasted but with swollen lower limbs. Classification of protein-energy malnutrition according to weight, height and oedema is summarized in Panel 2. Also shown are criteria for classifying severe malnutrition as ‘oedematous’, ‘wasted’ or ‘stunted’ (see also annex 5).

Vitamin and mineral deficiencies

These affect persons of all ages and are a particular danger in situations where supplies of fresh foods and produce are disrupted and the nutritional quality of the diet is reduced. Symptoms of malnutrition caused by vitamin or mineral deficiency vary enormously, depending on the specific nutrient deficiency. Possible forms of malnutrition caused by vitamin or mineral deficiency are summarized in Panel 1.

Nutrition Assessment

Assessment of physical signs of malnutrition

Severe stages of malnutrition in children, including many micronutrient deficiencies, are easy to detect. Annex 1 depicts the signs of severe malnutrition that field workers can be quickly trained to diagnose. It is estimated, however, that mild and moderate malnutrition account for about 80 percent of the mortality associated with malnutrition in young children. Therefore, the assessment, prevention and treatment of these forms of malnutrition are also essential.

Assessment of malnutrition should have two basic components:

- assessment of the physical signs of malnutrition, including of micronutrient deficiencies where possible;
- assessment of the causes of malnutrition.

Each is critical for the development of effective strategies for addressing the nutrition problem.

UNICEF endorses the recommendation of WHO and the practice of an increasing number of NGOs to use weight-for-height for rapid assessment of overall malnutrition in emergencies. It is an objective measure, normally associated with less error than other indicators. Annex 2 has a detailed guide for conducting weight-for-height surveys of children.

Assessment of causes of malnutrition

The conceptual framework demonstrates that the causes of malnutrition are complex and appear at all levels of society. However, it is possible to quickly assess the key underlying causes – food access, care, health services and the environment – and their relative importance.

Annex 3 offers a tool for determining the present and near-term food access of households, to identify measures for reinforcing the capacity of households to ensure their own food security and to ascertain what type of food aid programme may be necessary. It focuses on the impact of the emergencies on households’ usual means of acquiring food (i.e. breakdown of food production systems, markets, income-earning opportunities, opportunities for barter, social networks, etc.).
Field-Level Strategies and Actions

Field-level strategies and actions must address each of the underlying causes of the malnutrition in emergencies described above (i.e. access to food, caring practices, access to health services, and the environment) and their relative importance in the situation. The current section and the attached technical annexes deal primarily with food access issues and one particular element of caring practices – infant feeding practices. Guidance in addressing issues related to health services, the environment and other caring practices are provided elsewhere in this handbook.

Ensuring access to food

Ensuring household food security (HFS), i.e. the capacity of households to have access to adequate food for all members at all times of the year, should be the main strategic thrust of food-related activities. If households are not intact, the strategic aim should be providing adequate food for all individuals.

The primary strategy should always be to reinforce the capacity of households to ensure their own food security. This capacity should be assessed as a matter of high priority and barriers understood and removed as possible. When it is clear that households are unable to acquire adequate food on their own, or when households are not intact, food security measures should be taken, and are described briefly below and in more detail in the attached annexes.

‘Non-relief’ forms of food security measures

From the earliest possible moment and to the maximum extent possible, food aid and other HFS assistance should support food self-reliance and rehabilitation. Emphasis should be placed on restoring food production, food marketing systems and employment, to improve the long-term food security of households and communities.

There are wide ranges of ‘non-relief’ actions that may be taken in an emergency to help promote, re-establish or reinforce household food autonomy. Panel 2 indicates some such actions in a variety of emergency scenarios.

General feeding

Feeding programmes are required where other means of food access are minimal or non-existent. This may be the case during the early stages of a complex emergency involving population displacement and a breakdown in economic and social structures. The principal strategy of feeding programmes should be to provide a general ration to all households. The ration must make up the difference between what the beneficiaries need and what they can supply for themselves, in order that the total food needs – micronutrient as well as protein and energy – of all household members, including young children, are met.

General rations should only be introduced when absolutely necessary and for as short a period as possible. They should not be a disincentive to either self-help efforts on the part of able-bodied beneficiaries or the re-establishment of local food production and marketing systems, nor attract people from other areas. They should be distributed in a way that strengthens the capacity of families to stay together and to be active in feeding their members.

Supplementary feeding

Supplementary feeding involves the provision of additional food to selected, nutritionally vulnerable groups – particularly under-fives and pregnant and lactating women – to compensate for deficiencies in energy, protein and micronutrients in the food available. Food may be provided as cooked meals (‘on-site’ or ‘on-the-spot’ feeding) or as dry, ‘take-home’ rations, and should supplement rather than replace, general rations or other sources.

Supplementary feeding should be a short-term ‘damage-control’ measure to protect the nutritional status of vulnerable groups until adequate general rations can be assured or the households’ ability to meet their own food needs is re-established. Such programmes are generally not desirable and should be established only
when it is impossible to meet the nutritional needs of vulnerable family members through the general ration. This may occur when the family is unable to look after the needs of its most vulnerable members, and in sudden-onset emergencies.

Therapeutic feeding

In emergency situations where severe malnutrition among infants and young children is widespread, most commonly when families have disintegrated and caregivers are under extreme stress, therapeutic feeding can be an urgent life-saving intervention. Therapeutic feeding must take place on an in-patient basis wherever possible, necessitating special therapeutic feeding centres where the health system is dysfunctional or overwhelmed. Such centres should be established when incidence of malnutrition (weight-for-height < −2 SD of reference population) is over 10 percent of children aged six months to five years. One centre should serve up to 100 persons.

Therapeutic feeding should only be seen as a short-term curative measure until overall nutrition conditions improve. It must be conducted alongside, rather than at the expense of, preventative nutrition measures; particular caution must be exercised that it not use up a disproportionate number of scarce trained health personnel.

Infant feeding and related care

Ensuring proper infant feeding and related care is particularly important in an emergency, when infants are most vulnerable to malnutrition, disease and infection. Three critical elements of infant feeding in an emergency (as well as in normal circumstances) – breastfeeding, use of breastmilk substitutes and complementary feeding – are described briefly below and in more detail in annex 4.

Protection, promotion and support of breastfeeding

Breastfeeding is virtually always desirable, and even more critical in emergencies, when it may be the only sustainable element of food security for the child. The immunological, psychological (bonding, care) and physical (warmth, etc.) benefits of breastfeeding are crucial in emergency situations. Every effort must be made to protect, promote and support breastfeeding in an emergency, even if the emergency is in a society in which breastfeeding is not otherwise widely practiced. The following guidelines are important during emergencies:

- Breastfeeding is best for babies and must be promoted and continued for as long as possible.
- Use of colostrum is especially important and infants should be breastfed on demand from birth.
- Breastmilk alone supports child growth and development through about six months of age, and exclusive breastfeeding should be promoted during this period.
- When appropriate complementary foods are unavailable it may be preferable to prolong exclusive breastfeeding from the usual 6 months to 7–8 months.
- Additional food assistance should be provided for mothers for the two years of lactation if general rations do not provide the additional nutrients and calories required for breastfeeding.
- Where water is closely rationed, give breastfeeding mothers an extra litre of drinking water each day.

Relactation

- Restimulate lactation in cases where milk production has been affected by stress.
- Relactation, i.e. restimulation of lactation in a woman who has ceased to breastfeed, is often possible even among women who are sick or malnourished.
Use of breastmilk substitutes

- Avoid reliance on breastmilk substitutes to the extent possible. All reasonable efforts should be made to ensure breastfeeding or breastmilk for infants before breastmilk substitutes are used.

- Mothers giving birth after the start of an emergency should receive Baby-Friendly maternity care which facilitates establishment of exclusive breastfeeding.

- Milk products, especially powdered milk, and infant formulas can cause health problems and they are often inappropriate.

- The distribution and use of breastmilk substitutes must be strictly controlled to avoid any suggestion that they are preferable to breastfeeding and the use of appropriate local foods.

- Ban baby bottles completely.

- Infant formulas should be used only under strictly controlled conditions, with a cup (or giving a few feeds by spoon before transition to a cup).

- All distribution and use of breastmilk substitutes is potentially disruptive of breastfeeding and conditions for their safe use, i.e. proper hygiene and clean, boiled water and proper dilution, are often very difficult to ensure.

- Ensure that every child who must use breastmilk substitutes has a supply that is adequate to meet his or her full need, normally until the age of about one year at least. One infant’s supply for a full year is 40 kg of powdered infant formula or 20kg of formula followed by a 20kg of dried full cream milk.

- The caregivers’ access to the necessary cooking fuel, clean utensils, and water needed to prepare breastmilk substitutes must be assured.

- Breastmilk substitutes should conform to the nutrient standards defined by Codes Alimentarius. If formula is prepared from fresh or dried animal milk, addition of micronutrients is recommended.

Complementary Feeding

Complementary feeding is the addition of other foods while breastfeeding is continued. Complementary foods, although they should be rich in energy and nutrients, are not adequate breastmilk substitutes in the first year of life. Good complementary feeding, a principal means of preventing malnutrition, may be difficult to ensure in emergencies, when traditional food supplies and child care systems are often disrupted.

- Traditional complementary feeding practices must be observed, understood, and if compatible with sustained breastfeeding, supported in consultation with local public health personnel including health workers, traditional birth attendants, nurse-midwives, paediatricians and nutritionists.

- IEC activities promoting proper complementary feeding practices should be implemented making use of local communication agents.

- Food assistance must include appropriate complementary foods for young children. These should be nutrient-dense (high-calorie, protein and micronutrient rich) and to the extent possible, be composed of foods that are familiar. Dried milk may be mixed into these foods as
long as the infant ultimately takes in about 100g of DFSM per day.

- Complementary foods must be appropriate; foreign baby foods and special foods often are not. Commercial complementary foods or baby foods should not be distributed in emergencies. Their packaging and liquid content make their transportation, storage and handling prohibitively expensive.

- Instructions to food preparers should be understandable and use locally familiar measures.

- Communal preparation of complementary foods may be useful or necessary, particularly when access of individual households to fuel, utensils, etc., is limited or when mothers need support in accepting and using unfamiliar foods. The mothers themselves should be largely responsible for such operations, guided by trained women demonstrators.

Replacement Feeding

Replacement feeding means the process of feeding a child who is not receiving any breastmilk with a diet that provides all the nutrients the child needs.

- Infants and young children who cannot be breastfed require replacement feeding.

- Up to six months, this should be with a suitable breastmilk substitute, which may be infant formula or be prepared from animal milk and micronutrients.

- After six months, it should be with a suitable breastmilk substitute or 20kg of DFCM either as liquid or mixed into other food. Complementary foods made from appropriately prepared and nutrient–enriched family foods should be given three times a day.

- If milk products are not available, appropriately prepared family foods should be further enriched and given five times a day.

Coordination and Partnerships

Principal partner agencies in nutrition in emergencies

NGOs

* Nutrition assessment, rehabilitation of severe malnutrition and supplementary feeding

  - Médecins sans Frontières (all)
  - Action Contre la Faim
  - Save the Children (UK especially)
  - International Medical Corps
  - Médecins du Monde/Doctors of the World
  - Concern (Ireland)
  - Merlin (Ireland)
  - ICRC

* Supplementary feeding

  - CARE International
  - Catholic Relief Services
  - ICRC

* Infant feeding

  - IBFAN
  - Linkages
• IFEG: UK Ad Hoc Group on Infant Feeding in Emergencies

**Food and nutrition assessment**

• OXFAM – UK

**UN agencies**

• WFP (food assistance, some assessment)
• UNHCR (basic needs in refugee situations)
• WHO (normative guidelines)

NOTE: Much of the nutrition work of WFP and UNHCR is done through contracted NGOs.

**Further Guidance**

**General nutrition**

ACC Sub-Committee on Nutrition, report of a workshop on improvement of the nutrition of refugees and displaced people in Africa, Machakos, Kenya, December 1994


UNHCR, *Handbook for Emergencies* (2d ed.).


**Food security assessment**


Infant feeding


Malnutrition, nutrient requirements, etc.


Panels

Panel 1 – Possible Vitamin/Mineral Deficiencies

<table>
<thead>
<tr>
<th>POSSIBLE VITAMIN/MINERAL DEFICIENCIES</th>
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<tbody>
<tr>
<td><strong>Anemia:</strong> Caused by parasitic infections, low intake and/or poor absorption of iron and folic acid. Tongue, finger nails and inside of lower eyelids appear unusually pale.</td>
</tr>
<tr>
<td><strong>Vitamin A deficiency (xerophthalmia):</strong> Signs are poor vision in the dark, dryness or foamy material on the white of the eye and/or clouding of the cornea (the dark of the eye).</td>
</tr>
<tr>
<td><strong>Vitamin−B1 deficiency (beri−beri):</strong> Loss of appetite, malaise and severe weakness, especially in the limbs. May also lead to paralysis of the limbs or swelling of the body, heart failure and sudden death. Occurs when diet consists almost exclusively of white polished rice or starchy staples such as cassava.</td>
</tr>
<tr>
<td><strong>Niacin deficiency (pellagra):</strong> Skin rash on parts of the body exposed to sunlight. Occurs especially where maize and sorghum are the staples and other foods are lacking.</td>
</tr>
<tr>
<td><strong>Vitamin−C deficiency (scurvy):</strong> Swollen gums that bleed easily; swollen, painful joints. Occurs when fruits and vegetable are lacking.</td>
</tr>
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Panel 2 – Emergency Scenarios and Non−Relief Responses

<p>| EMERGENCY SCENARIOS AND NON−RELIEF RESPONSES |</p>
<table>
<thead>
<tr>
<th>Scenario</th>
<th>Possible Actions</th>
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<table>
<thead>
<tr>
<th>Scenario</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adequate food available locally but emergency-affected households have inadequate purchasing power or goods to barter to ensure acquisition of enough food for all members.</td>
<td>Income-generating activities, employment programmes, or food-for-work schemes, based on pre-emergency experiences (see main text below). Purchase of significant quantities of food for redistribution through food-price subsidies or subsidized ration schemes (coupons, food stamps). Food loans: Acquire significant quantities of food and lend to households for repayment to a community food bank after the next harvest or as other assets are acquired.</td>
</tr>
<tr>
<td>2. Adequate food is available in-country and some people have capacity to acquire it, but markets/infrastructure are disrupted by the emergency.</td>
<td>Acquire significant quantities of food and sell to merchants or vendors at below-market prices for resale at a fair price (e.g., previous year's price adjusted for inflation). Rebuilding of physical infrastructures of markets or other infrastructures using FFW or other employment programmes. Where cash is scarce or of limited value, it may be useful to stimulate a barter economy by distributing tradables (basic household goods, etc.) to be bartered for food.</td>
</tr>
<tr>
<td>3. Adequate food available locally and people have capacity to acquire it, but people have little capacity to prepare, transform or store it.</td>
<td>Provision or subsidized rationing of equipment for milling, grinding, drying, other transformation. Rebuilding of food storage facilities; use of common storage facilities, managed by the affected population where appropriate.</td>
</tr>
<tr>
<td>4. Adequate food not available locally but harvest is expected in the short term.</td>
<td>Food lending using food aid commodities. Investigate possibilities for borrowing purchase (using monetization of food aid), or swap of outside food with food from a nearby region. Short-term outside food aid programme through the period of harvest and food transformation.</td>
</tr>
<tr>
<td>5. Adequate food not available locally but local food production possibilities exist.</td>
<td>Short-term outside food aid accompanied by support to food production.</td>
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Chapter 2 – Annex 1: Therapy for Severe Malnutrition

Introduction

This annex provides guidelines for the management of persons (mostly children) with severe malnutrition, including severe micronutrient deficiencies, and relies heavily on WHO’s ‘Management of the child with severe malnutrition’ (1995). Further details may be found in that manual.

The goal of the therapeutic practices described here is to reduce the risk of death, shorten hospitalization and facilitate full recovery. Severe malnutrition among children is a common problem in emergencies, particularly where families have disintegrated and parents and caretakers are themselves under extreme stress. Despite the difficulty and complexity of the problem, malnutrition must be treated carefully and given top priority.
because it so markedly increases the risk of death.

Management of the child with severe malnutrition is divided into three phases. These are:

1. **Initial treatment**: Life-threatening problems are identified and treated; specific deficiencies are corrected; metabolic abnormalities are reversed and feeding is begun.

2. **Rehabilitation**: Intensive feeding is given to recover most of the lost weight; emotional and physical stimulation is increased; the mother is trained to continue care at home; and preparations are made for discharge of the child;

3. **Follow-up**: After discharge, the child and family are followed to prevent relapse and ensure continued physical, mental and emotional development.

A typical time-frame for the phases of treatment and problems encountered is shown in Panel 1.

Successful management of the severely malnourished child does not necessarily require sophisticated facilities and equipment, or highly qualified personnel. It does require, however, that each child be treated with tender, loving care and that each phase of treatment be carried out fully and carefully by appropriately trained and dedicated health workers. When this is done the risk of death can be substantially reduced and the opportunity for full recovery greatly improved. The goal in all situations should be a case fatality rate of under 5 per cent.

Treatment facilities

Residential care is essential for initial treatment and for the beginning of rehabilitation of a child with severe malnutrition.

If the health system is functioning, the child should be admitted to hospital, preferably to a Special Nutrition Unit dedicated to the initial management and rehabilitation of severe malnutrition. In many emergencies, however, it will be necessary to set up a therapeutic feeding centre (TFC) to manage large numbers of severely malnourished children. This is usually necessary when a cluster survey shows >10% of children, age 6 months to 5 years, with weight-for-height <80% (2SD) of reference values.

Establishing a TFC requires the following:

- **Location and capacity:**

  The TFC should be in or near a hospital compound. It may be housed in simple buildings or tents. One TFC should serve up to 100 children. If the number is greater, a second TFC should be organized. Each TFC should include a special care unit (SCU), to provide 24-hour care during initial treatment, and a day care unit (DCU), for care during rehabilitation.

- **Water supply and sanitation:**

  Thirty litres of water should be available per child, per day. A TFC cannot function with less than 10 litres per child, per day. A latrine and a bathing area are required for every 20 persons.

- **Kitchen, food, storage and supplies:**

  A collective kitchen should be organized and a reliable supply of fuel for cooking ensured. The food requirement should be based on the estimated number of severely malnourished children, plus food for their mothers or caretakers. Secure storage facilities are required for food and medical supplies. Panel 2 suggests the utensils and other items that might be required for a TFC serving 100 severely malnourished children.

- **Minimum staff:**

  This should include, 1 part-time doctor, 3 nurses to provide service 24 hours per day, 10 nursing aides, and the mothers or caretakers of the children. Written guidelines should be provided in an appropriate language and rapid orientation training organized for all personnel involved. Many doctors and nurses have little
experience in nutrition or in treating severe malnutrition.

When the child has completed the initial phase of treatment, is without complications, and is eating satisfactorily and gaining weight (usually 23 weeks after admission), he or she can usually be managed at the daycare unit (DCU) if the child has somewhere safe to go at night.

TFC monitoring and evaluation

A medical and/or nutrition team should monitor the health and nutrition status of the entire population by: (1) calculating mean daily mortality rates at weekly intervals, (2) monitoring food availability, including its macro- and micronutrient content, at regular intervals, and (3) conducting periodic anthropometric (weight and height) surveys.

Using these data, the coverage, success and mortality rates of the TFC’s should be regularly evaluated by the following criteria:

• **Coverage rate:**

  The number of severely malnourished children enrolled divided by the total of severely malnourished children in the population, based on the most recent survey.

• **Success rate:**

  The number of children reaching criteria for discharge divided by the number of children enrolled in the centre.

• **Mortality rate:**

  The number of deaths in the centre divided by the number of children enrolled in the centre.

The interpretation of these figures depends on local conditions, resources and agreed health priorities. Most programs can cover >80% of severely malnourished children, with success rates of >50%. The goal is to attain mortality rates of <5%, though this is difficult in some emergencies.

Evaluation of the malnourished child

When first seen, the child must be examined, a history taken and a decision made on the treatment to be given. Treatment should be started immediately after the history, examination, weighing and measuring are completed. Details of the history and examination should be recorded later. Very sick children respond badly to frequent handling. They should not be taken for X−rays; clinical specimens should be taken in the bed.

Nutritional status and admission criteria

Assessment of nutritional status according to weight, height and oedema is summarized in Panel 4. Also shown are the criteria for classifying severe malnutrition as ‘oedematous’, ‘wasted’ or ‘stunted’. Normal values for weight for height or length, are given in Annex 5. Children whose weight−for−height is <70% of the median (3SD) of NCHS reference values (termed ‘wasted’), or who have symmetrical oedema involving at least the feet (termed ‘oedematous malnutrition’) are severely malnourished. They should be admitted to a special care unit in the TFC where they can be observed, treated and fed day and night.

History and examination

Points of special importance in the child’s history and physical examination are listed in Panel 5. It helps to use a printed proforma so that information is collected and recorded in a standard manner (see Panel 3).
Laboratory tests

Where facilities permit, the tests given in Panel 6 may help to diagnose specific problems. They are not needed, however, to guide or monitor treatment. The interpretation of test results is frequently altered by malnutrition. For this reason, laboratory tests may misguide inexperienced workers. The most important guide to treatment is frequent careful assessment of the child.

Initial treatment

Principles of management

When first seen, the child with severe malnutrition is often a medical emergency. The child is ‘wasted’, usually anorexic, often infected and appears seriously ill. Wherever possible, the child should be referred to hospital. Successful initial management requires frequent, careful clinical evaluation and anticipation of common problems so they can be prevented, or recognized and treated at an early stage. The physiology of the malnourished child is seriously abnormal; more details on how these abnormalities affect treatment may be found in WHO’s Management of the child with severe malnutrition (1995).

Recently admitted children should be kept in a special area where they can be constantly monitored. Because they are very susceptible to infection, this area should, if possible, be isolated from other patients. The child should not be kept near a window or in a draft, and windows should be closed at night. The child should be properly covered with clothes, including a hat, and blankets. Washing should be kept to a minimum and, if necessary, done during the day. When the child is washed, he or she must be dried immediately and carefully. The room temperature should be kept at 25−30 degrees C (77−86F). This will seem uncomfortably warm for active, fully clothed staff, but is necessary for small, immobile children who easily become hypothermic.

Intravenous infusions should be avoided except when essential, as for severe dehydration or septic shock. Intra−muscular injections should be given with care in the buttock, using a small gauge needle and the smallest possible volume.

Initial treatment begins with admission to hospital and lasts until the child’s condition is stable and the child can eat, which is usually 27 days. If the initial phase takes longer than 10 days, the child is ‘failing to respond’ and additional measures are required. The principal tasks during initial treatment, in order of priority, are to:

1. treat or prevent hypoglycaemia and hypothermia;
2. treat or prevent dehydration and restore electrolyte balance;
3. treat incipient or developed septic shock, if present;
4. start to feed the child;
5. treat infection; and
6. identify and treat other problems, including vitamin deficiency, severe anaemia and heart failure.

Hypoglycaemia

All severely malnourished children are at risk of developing hypoglycaemia (blood glucose <3 mmol/l or <54 mg/dl), which is an important cause of death during the first two days of treatment. Hypoglycaemia may be caused by serious systemic infection or can occur when a malnourished child has not been fed for 4–6 hours, as often happens during travel to hospital. Signs of hypoglycaemia include low body temperature, lethargy,
limpness and clouding of consciousness. Sweating and pallor do not usually occur in malnourished children. Often, the only sign before death is drowsiness. The best way to prevent hypoglycaemia is to give food at least every 2–3 hours, day and night (see Section 4.5).

Treatment

If hypoglycaemia is suspected, treatment should be given immediately without laboratory confirmation; it can do no harm, even if the diagnosis is incorrect.

- If the patient is conscious or can be roused and will drink, give 50 ml of 10% glucose or sucrose in water, or give F–75 diet by mouth (see Section 4.5), whichever is available most quickly. Stay with the child until he or she is fully alert.

- If the child is losing consciousness, cannot be aroused or has convulsions, give 1 ml/kg body weight of sterile 50% glucose intravenously (IV), followed by a nasogastric (NG) infusion of 50 ml of 10% glucose or sucrose, to prevent a recurrence. If the dose of IV glucose cannot be given quickly, give the NG infusion first.

- When the child regains consciousness, immediately begin feeding F 75 diet or glucose in water (60 g/ l). Continue frequent oral (or NG) feeding with F 75 diet to prevent a recurrence.

- Every malnourished child with suspected hypoglycaemia should also be treated with broad spectrum antimicrobials for serious systemic infection.

Hypothermia

Young infants, and those with marasmus, large areas of weeping skin or serious infection, are highly susceptible to hypothermia.

Treatment

- When rectal temperature is <35.5C (<95.9F) or under−arm temperature <35C (<95F) the patient should be warmed.

- The means of warming is to use an adult’s body heat in the ‘kangaroo technique’: the mother lies down supine, and the infant is placed on the mother’s chest, against her skin, and covered with the mother’s clothes and blankets.

- If the mother or another willing adult is not available, the child can be warmed by wrapping in blankets and placing an incandescent lamp over (but not touching) the child’s body. Hot−water bottles are dangerous and should not be used.

- Rectal temperature must be measured every 30 minutes during re−warming with a lamp, as the child may rapidly become hypothermic. During re−warming, temperature under the arm is not a satisfactory guide to body temperature.

- All hypothermic children must also be treated for hypoglycaemia and for serious systemic infection.

Dehydration and septic shock

Dehydration and septic shock are difficult to differentiate in a child with severe malnutrition. Both show signs of hypovolaemia, and the effects progressively worsen if treatment is not given. Dehydration progresses from ‘some’ to ‘severe’, reflecting 5−10% and >10% weight loss, respectively; whereas septic shock progresses from ‘incipient’ to ‘developed’, as blood flow to vital organs decreases. Moreover, in many cases of septic
shock, there is a history of diarrhoea and some degree of dehydration, giving a mixed clinical picture.

Many signs normally used to assess dehydration are unreliable in a child with severe malnutrition, making it difficult or impossible reliably to detect dehydration or determine its severity. Moreover, many signs of dehydration are also seen in septic shock. This results in a tendency for dehydration to be overdiagnosed and its severity overestimated, and makes it often necessary to treat the child for both dehydration and septic shock. Panel 7 provides the compared features of dehydration and septic shock in the severely malnourished child.

With incipient septic shock, the child is usually limp, apathetic and profoundly anorexic, but is neither thirsty nor restless. With developed septic shock, superficial veins, such as the external jugular and scalp veins, are dilated rather than constricted. The veins in the lungs also may become engorged, making the lungs stiffer than normal. For this reason the child may groan, grunt, have a shallow cough and appear to have difficulty breathing. As shock worsens the child develops kidney, liver, intestinal or cardiac failure. There may be ‘coffee ground’ vomiting, blood in the stool, and abdominal distension with a ‘splash’ and intestinal fluid levels on X−ray. When a child reaches this stage, survival is unlikely.

Treatment of dehydration:

- Whenever possible, a dehydrated child with severe malnutrition should be rehydrated orally. IV infusion easily causes overhydration and heart failure. It should be used only when there are definite signs of shock.

- Full strength ORS solution should not be used. As total body potassium is low and total sodium is high, the rehydration solution should contain less sodium and more potassium than standard WHO ORS solution. Magnesium, zinc and copper should also be provided to correct deficiencies of these minerals.

- The recommended solution, which is called ‘ReSoMal’, is made by diluting one standard WHO ORS packet in two litres of water, instead of one litre, and adding: 50 g of sucrose (25 g per litre) and two packets of ‘mineral mix’ or 40 ml (20 ml/litre) of concentrated mineral mix solution (see Panel 8).

- Between 70 and 100 ml of ReSoMal per kg body weight is usually enough to restore normal hydration. Give this amount over 12 hours, starting with about 10 ml/kg per hour for the first two hours, and then giving 5 ml/kg per hour. This rate is slower than for children who are not severely malnourished. Reassess the child at least every hour. The exact amount to give should be determined by how much the child will drink, the amount of ongoing stool loss, and any signs of overhydration, especially signs of heart failure. ReSoMal should be stopped if: (1) the respiratory rate increases, (2) the jugular veins become full, or (3) there is increasing abdominal distension.

- A child who can drink should be given 45 ml of ReSoMal every few minutes by spoon. However, malnourished children are weak and quickly become exhausted, so they may not continue to take enough fluid voluntarily. When this happens, give ReSoMal as a drip by NG tube at the same rate as orally. An NG tube should be used from the start in all weak or exhausted children, and in those who vomit, have a rapid respiratory rate or painful stomatitis.

- Rehydration is completed when the child is no longer thirsty, urine is passed and any other signs of dehydration have disappeared. Fluids given to maintain hydration should be based on the amount of ongoing stool losses and the child’s willingness to drink. As a guide, after each loose stool, give a child less than two years old 50−100 ml (a quarter to half a large cup) of ReSoMal. Continue this treatment until diarrhoea stops.

- **Intravenous rehydration:**

  - The only indication for IV infusion in a severely malnourished child is circulatory collapse caused by severe dehydration or septic shock. Use one of the following solutions (in order of preference): (1) half−strength Darrow’s solution with 5 per cent dextrose; (2) Ringer’s lactate solution with 5 per cent dextrose, or (3) 0.45 per cent (half−normal) saline with 5 per cent
dextrose. Give 15 ml/kg IV each hour for two hours and monitor the child carefully for signs of overhydration. While the IV drip is being set up, also pass an NG tube and give ReSoMal through the tube (10 ml/kg per hour). After two hours, discontinue the IV infusion and continue rehydration orally or by NG tube as described above. At this time, the child should have a strong radial pulse. If the radial pulse is still absent, septic shock is likely and further treatment should follow guidelines for that condition.

• Feeding during rehydration:

• Breastfeeding should be offered every half hour without interruption. Begin to give the F75 diet as soon as possible, orally or by NG tube, usually within 2–3 hours after starting rehydration (see amounts in Panel 10). If the child is alert and drinking, give the diet immediately, even before rehydration is completed. Usually the diet and ReSoMal are given in alternate hours. If the child vomits, give the diet by NG tube. When the child stops passing watery stools, continue feeding.

Treatment of septic shock:

Any severely malnourished child with signs suggesting incipient or developed septic shock should be treated for septic shock. This includes especially children with: (1) signs suggesting dehydration, but without a history of watery diarrhoea, (2) hypothermia or hypoglycaemia, and (3) oedema and signs suggesting dehydration.

• Every child with septic shock should immediately be given broad spectrum antibiotics.
• They should be kept warm to prevent or treat hypothermia.
• Children with septic shock should not be handled any more than is essential for treatment. Nor should the child be washed or bathed; his or her bottom can be cleaned with a damp cloth. Iron should not be given.

Dietary treatment

Children who do not require other emergency treatment, especially for hypothermia, dehydration or septic shock, should immediately be given a formula diet. Mothers should continue to breastfeed regardless of other foods and treatments.

The basic formula diets:

• Almost every severely malnourished child has infection, liver and intestinal dysfunction, and electrolyte imbalance when first admitted to hospital. Because of these, the child does not tolerate the usual amounts of dietary protein, fat and sodium. It is important, therefore, initially to give the child a diet that is low in these ingredients and high in carbohydrate. The daily requirements of the severely malnourished child are given in Panel 9.

• Two formula diets are used for severely malnourished children. The first, F 75 (75 kcal/100 ml), is used during the initial phase of treatment. The second, F 100 (100 kcal/100 ml), is used during the rehabilitation phase, after the appetite has returned. These formulas can be purchased as a powder that is simply mixed with water, or they can easily be made in a hospital kitchen from the following basic ingredients: cereal flour, dried skim milk, sugar, oil, mineral mix and vitamin mix (Panel 10). The recipe for the vitamin mix is in Panel 11.

• The mineral mix (Panel 11) supplies potassium, magnesium and other essential minerals; it must be added to the diet. The potassium deficit, present in all malnourished children, adversely affects cardiac function and gastric emptying. Magnesium is essential for potassium to enter cells and be retained. Panel 12 shows the desirable daily nutrient intake.
Feeding on admission:

- To avoid overloading the intestine, liver and kidney, it is critical that food be given frequently and in small amounts. Children too weak to eat should be fed by continuous NG drip (do not use IV feeding). Children who can eat should be given the diet in hourly, two-hourly or three-hourly portions, day and night. If vomiting occurs, give smaller feeds more frequently.

- The F 75 diet is advised for all children during the initial phase of treatment. The child should be given at least 80, but not more than 100, kcal/kg per day. If less than 80 kcal/kg per day are given, the child will continue to break down his or her own tissues and will deteriorate. If more than 100 kcal/kg per day are given, the child may develop a serious metabolic imbalance. The volumes of F−75 needed for one−, two− and three−hourly feeds for children of various weights are given in Panel 9.

- Nearly all malnourished children have poor appetites when first admitted to hospital. Patience and loving care are needed to gently coax the child to complete each feed. Feed the child from a cup and spoon; feeding bottles should never be used, even in very young infants. While being fed, the child should always be held securely in a sitting position on the attendant’s or mother’s lap. Children should never be left alone in bed to feed themselves.

Nasogastric feeding:

- Despite coaxing and patience, many children will not take sufficient diet by mouth during the first few days of treatment. Common reasons include very poor appetite, weakness and painful stomatitis. Such children should be fed by NG tube. However, NG feeding should end as soon as possible.

- At each feed, the child should first be offered the diet orally, even though a tube is in place. After the child has taken as much as he or she wants, the remainder is given by tube. When the child is taking three quarters of the day’s diet orally, or takes two consecutive feeds fully by mouth, the tube should be removed. If over the next 24 hours the child fails to take 80 kcal/kg, the tube can be reinserted. If the child develops abdominal distension during NG feeding, give 2 ml of a 50 per cent solution of magnesium sulphate intramuscularly.

Feeding after appetite improves:

- The child’s appetite is a barometer of progress: If it improves, the child is being successfully treated. The initial phase of treatment ends when the child becomes hungry. This indicates that infections are coming under control, the liver is able to metabolise the diet, and other metabolic abnormalities are much improved. The child is now ready to begin the rehabilitation phase. This usually occurs after 2 to 7 days. Some children with particularly complicated problems may take longer; whereas others are hungry from the start and can immediately be fed following guidelines for rehabilitation. It should be emphasized that it is the child’s appetite and general condition that determine the phase of treatment and not the length of time since admission.

- As soon as the child is taking 100 kcal/kg per day of F−75 orally, the diet should be changed to F−100, but intake should remain at 100 kcal/kg per day until steady weight gain is established. The amounts of diet to give are shown in Panel 9. All children receiving F−100 diet should be offered additional water between feeds.

Milk intolerance:

- Clinically significant milk intolerance is unusual in severely malnourished children. Intolerance should be diagnosed only if copious watery diarrhoea occurs promptly after milk feeds are begun, the diarrhoea clearly improves when milk intake is reduced or stopped, and it recurs when the child is given milk a second time. In addition, faecal pH is <5 and there are
increased faecal-reducing substances. In such cases, milk should be partially or totally replaced by another liquid food. Before the child is discharged, milk feeding should be attempted again to determine whether the intolerance has resolved.

Recording food intake:

- If possible, the type of feed given, the amounts offered and taken, and the time of day should be charted after each feed. This information will be useful in evaluating the effectiveness of the TFC and in investigating cases of failure to thrive. If the child vomits, the amount lost should be estimated in relation to the size of the feed, for example, a whole feed, half a feed, and so on, and deducted from the total intake. Once a day the caloric intake for the past 24 hours should be determined and compared with the child’s weight. If this shows the child has taken less than 80 kcal/kg, more should be given. If more than 100 kcal/kg have been given, the amount for each feed should be reduced.

Infections

Bacterial infections:

- Nearly all severely malnourished children have bacterial infections when first admitted to hospital. Many have several infections caused by different organisms. Infection of the lower respiratory tract is especially common.

- Although signs of infection should be carefully sought when the child is evaluated, they are often subtle or absent. Unlike well-nourished children with infection, who react with fever and inflammation, malnourished children with serious infections may only become apathetic or drowsy.

- Early treatment of bacterial infections with effective antimicrobials improves the nutritional response to feeding, prevents shock and reduces mortality. Because infections are so common and also difficult to detect, all children with severe malnutrition should routinely receive broad spectrum anti microbial treatment when first admitted for care. Each institution should have a policy on which antimicrobials to use.

Measles and other viral infections:

- Measles vaccine should be given to every malnourished child when admitted to hospital. This protects the hospitalized child from infection and the associated high mortality that might otherwise be introduced by a newly admitted child who is incubating measles. A second dose of vaccine should be given before discharge. (Chapter 3 on Providing Essential Health Services, Annex 5 gives details on the treatment of measles.)

Other problems

Vitamin A and other vitamin deficiencies:

- Severely malnourished children are at a high risk of developing blindness due to vitamin A deficiency. For this reason vitamin A should be given routinely to all malnourished children on admission. Start treatment immediately, giving large doses of vitamin A on the first two days. Before discharge give a third dose. Intra muscular treatment is preferred at the beginning in children with severe anorexia, oedematous malnutrition or septic shock; oral treatment is satisfactory for others. Water miscible retinyl palmitate should be used, if possible. The
treatment schedule is given in Panel 13.

• Great care must be taken during examination of the eyes, as they easily rupture in children with vitamin A deficiency. The eyes should be examined gently for signs of xerophthalmia, corneal wrinkling, dullness, xerosis and ulceration, and keratomalacia. If there is ocular inflammation or ulceration, protect the eyes with saline soaked pads. Tetracycline eye drops (1%) should be instilled 4 times a day until all signs of inflammation or ulceration resolve. Atropine eye drops should also be applied and the eye should be bandaged, as scratching with a finger can cause rupture of an ulcerated cornea. See also Chapter 3 on Providing Essential Health Services, Annex 5, for information on vitamin A supplementation with vaccination.

• All malnourished children should receive 5 mg folic acid orally on admission. Many children are also deficient in riboflavin, ascorbic acid, pyridoxine, thiamine and the fat soluble vitamins D, E and K. All diets should be fortified with these vitamins by adding the vitamin mix (Panel 11).

Very severe anaemia:

• If the haemoglobin concentration is less than 40 g/l (4g/100ml) or packed cell volume (haematocrit) less than 12%, the child has very severe anaemia, which can cause heart failure.

• Children with very severe anaemia need a blood transfusion. Give 10 ml packed red cells, or whole blood, per kg body weight slowly over 3 hours. If there are signs of heart failure (see below), blood should be withdrawn (2.5 ml/kg) before the transfusion is started and at hourly intervals during the transfusion so that the total volume removed equals the volume transfused.

• Where testing for HIV and hepatitis B is not possible, transfusion should be given only when haemoglobin falls below 30 g/l (or below 10% haematocrit), or when there are signs of life-threatening heart failure. Do not give iron during initial treatment, as it can have toxic effects and can reduce resistance to infection.

Congestive heart failure:

• This is usually a complication of overhydration (especially when an IV infusion or standard ORS solution is given), very severe anaemia, blood or plasma transfusion, or giving a diet with a high sodium content. The first sign of heart failure is an increasing respiratory rate (>40/min up to 2 years; >30/min above 2 years); treatment should be started when this occurs. Later signs are respiratory distress, rapid pulse, venous engorgement, cold hands and feet, and cyanosis of the finger tips and under the tongue.

• Heart failure must be differentiated from respiratory infection and septic shock. It is useful to recall that these usually occur within 48 hours of admission, whereas heart failure usually occurs somewhat later.

• When heart failure is caused by fluid overload, the following measures should be taken:

  • Stop all oral intake and IV fluids; the treatment of heart failure takes precedence over feeding the child.

  • No fluid should be given until the heart failure is improved, even if this takes 24 or 48 hours.

  • Give a diuretic intravenously. The most appropriate choice is furosemide (1 mg/kg).

  • Do not give digitalis unless the diagnosis of heart failure is unequivocal (jugular venous pressure is elevated) and the plasma potassium level is known to be normal. In that case, 5
mg/kg body weight of digoxin may be given intravenously as a single dose, or orally, if the IV preparation is not available.

**Dermatosis of kwashiorkor:**

- This is characterized by hypo- or hyper-pigmentation, shedding of skin in scales or sheets, and ulceration of the skin of the perineum, groin, limbs, behind the ears and armpits. There may be widespread weeping skin lesions that easily become infected. Spontaneous resolution occurs as nutrition improves. All children with this problem should receive systemic antibiotics.

- Atrophy of the skin in the perineum leads to severe napkin dermatitis, especially if the child has diarrhoea. The perineum should be left exposed to dry without napkins; if the perineum becomes colonized with candida, it should be treated with nystatin ointment or cream and the child should be given oral nystatin.

- In other affected areas, applying zinc and castor oil ointment, petroleum jelly or paraffin gauze dressings helps to relieve pain and prevent infection. The zinc supplement contained in the mineral mix is particularly important in these children, as they are usually severely deficient.

**Rehabilitation**

A child enters the rehabilitation phase when a good appetite returns. No child who is being tube fed is yet in the rehabilitation phase.

**Principles of management**

The main tasks during the rehabilitation phase are to:

- 1. encourage the child to eat as much as possible’
- 2. stimulate emotional and physical development, and
- 3. prepare the mother to continue to care for her child after discharge.

The child should remain in hospital for the first portion of the rehabilitation phase. When a child fulfils all the criteria in Panel 14, the child can be transferred to a day-care unit. This is often 2–3 weeks after admission to the special care unit.

**Nutritional rehabilitation**

The most important determinant of the rate of recovery is the amount of energy consumed. However, the child still has important deficits of protein and various micronutrients, including potassium, magnesium, iron and zinc. These must also be given in increased amounts. Young infants can be fed exclusively on liquid or semi-liquid formulas. It is usually appropriate to introduce solid foods for older children.

**Feeding children below 24 months of age:**

- During rehabilitation, F 100 diet should be given every 3 to 4 hours, night and day (i.e. 6–8 feeds a day; see Panel 10). Transition to the rehabilitation phase involves increasing the amount of diet given at each feed by 10 ml (e.g., if the first feed is 60 ml, the second should be 70 ml, the third 80 ml, and so on) until the child refuses to finish the feed. If this does not happen on the first day, the procedure should be continued on subsequent days.
• When a feed is not completed, the same amount should be offered at the next feed. If that feed is completed, the amount offered for the following feed should be increased by 10 ml. Continue this process until some food is left after most feeds. The amount being offered should then be dispensed for the child at each feed on subsequent days. The amounts of each feed offered and taken should be recorded on the feeding chart and any food not taken should be discarded; never reuse it for the next feed. During rehabilitation, most children take between 150 and 220 kcal/kg per day. If intake is not at least 130 kcal/kg per day, the child is failing to respond.

• The F−100 diet is a therapeutic milk designed to support rapid growth in severely malnourished children and is absorbed by the damaged intestine of older children. As such, in an emergency WHERE NOTHING ELSE IS AVAILABLE, it could be used (diluted into 2.8 instead of 2 litres) for infants FOR A SHORT TIME, although it has NOT BEEN TESTED IN THIS ROLE. It is very low in iron so that any infants given this diet is likely to develop iron deficiency. Also for the proper use of this commodity, it is important that it is not perceived as a breastmilk substitute. (Annex IV, Infant Feeding in Emergencies: policy, strategy & practice. 1999. Emphasis added)

• During the first few days of rehabilitation, oedematous children may not gain weight, despite an adequate intake. This is because oedema fluid is being lost while tissue is being restored. Thus, progress in these children is seen as decreased oedema rather than rapid weight gain. If the child is neither gaining weight nor losing oedema, or if there is increasing oedema, the child is failing to respond.

• F−100 should be continued until the child achieves 90% weight−for−height. When this happens appetite diminishes and increasing amounts of food are left uneaten. The child is now ready for the discharge phase of treatment.

Feeding older children:

• The older child can also be successfully treated with increasing quantities of F−100; it is not essential to use a different diet. This has practical value in refugee camps, where it is important to use a mini−mum number of different diets.

• For most older children, however, it is appropriate to introduce solid food, especially for those who want a mixed diet. Most traditional mixed diets have a lower energy density and a higher water content than liquid diets. They are also relatively deficient in minerals, particularly potassium and magnesium, and contain substances that inhibit the absorption of zinc, copper and iron. Moreover, the diets are usually deficient in various vitamins. Thus, local foods should be fortified to increase their content of energy, minerals and vitamins. Oil should be added to increase energy density, and the mineral and vitamin mixes used in F−100 should be added after cooking. Other ingredients, such as dried skim milk, may be added to increase energy content. The mixed diet should contain at least 1 kcal/g.

• To avoid the effects of food substances that reduce the absorption of minerals, F−100 should be given between feeds of the mixed diet. For example, if the mixed diet is given three times daily, F100 should also be given three times daily, making six feeds a day.

• At the beginning of rehabilitation older children should be fed every 4 hours day and night (6 times per 24 hours). When they are growing well and are no longer vulnerable to hypothermia or hypoglycaemia, one of the nighttime feeds can be omitted, making 5 feeds per 24 hours.

Vitamins and minerals, including iron:

• Nearly all severely malnourished children have anaemia and should be given supplemental folic acid and iron. The children also should continue throughout rehabilitation to receive the vitamin and mineral mixes added to their food. Iron should only be given orally, never by injection. A child with moderate or severe anaemia should be given the equivalent of 30 mg
per day of elemental iron (3 mg/kg per day) in a single dose or, for children under 1 year old, divided in 2 daily doses. This should be given daily for 2 or 3 months, depending on the severity of the anaemia. It is preferable to give iron supplements between meals, using a liquid preparation.

• The child also should be given at least 100 micrograms per day of folic acid, unless the diet is fortified with this vitamin. If tablets containing 30 mg elemental iron and 100 micrograms folic acid are available, one tablet may be given daily during rehabilitation. For infants and young children, tablets can be ground and dissolved, or mixed with food.

Assessing nutritional progress:

• If possible, the child should be weighed daily and the weight plotted on a graph. It is useful to mark the 90% weight–for–height point on the graph, which is the target weight for discharge. The usual weight gain is about 10–15g/kg per day. A child who does not gain at least 5 g/kg per day for any 3–day period is failing to respond to treatment. With high–energy feeding, most severely malnourished children reach 90% weight for height after 46 weeks.

Emotional and physical stimulation

Severely malnourished children have delayed mental and behavioural development, which, if not treated, can become the most serious long–term result of malnutrition. Emotional and physical stimulation through play programmes that start during rehabilitation and continue after discharge can substantially reduce the risk of permanent mental and emotional damage.

It is essential that the mother be with her child in hospital and at the NRC, and that she be encouraged to feed, hold, comfort and play with her child as much as possible. Toys should be available in the child’s cot and room, as well as the play area. Inexpensive and safe toys made from cardboard boxes, plastic bottles, tin cans and similar materials are best because mothers can copy them.

Emotional stimulation and play:

• Care must be taken to avoid sensory deprivation. The child’s face must not be covered; the child must be able to see and hear what is happening around him or her. The child should never be wrapped or tied. The malnourished child needs interaction with other children during rehabilitation. After the initial phase of treatment, the child should spend prolonged periods with other children on large play mats, and with the mother or a play guide.

Physical activity:

• Physical activity promotes the development of essential motor skills and may also enhance growth during rehabilitation. For immobile children, passive limb movements and splashing in a warm bath are helpful. For mobile children, play should include such activities as rolling or tumbling on a mattress, kicking and tossing a ball, climbing stairs, and walking uphill and down. The duration and intensity of physical activities should increase as the child’s condition improves.

Training parents and caretakers

It is not always possible in emergency situations to focus on the training of parents or other caretakers, to help them prevent the recurrence of malnutrition, including through good feeding and understanding the importance of good health care and mental and emotional stimulation. This kind of training is the key, however, to the child’s long–term well–being. Links should be made with local educators or health workers, if
possible, to ensure some basic teaching of mothers and caretakers in basic home care in difficult circumstances.

Mothers should also be with their children in the day−care unit of the TFC as much as possible and should help with basic tasks. Mothers can be organized as an auxiliary work force for some tasks. The staff must be friendly and treat the mothers as partners in the care of the children. A mother should never be scolded, blamed for her child’s problems, humiliated or made to feel unwelcome.

Discharge

Children should not be discharged from care until they are at about 90% weight for height (1 SD) on two consecutive weighings. In addition, insofar as possible, the other criteria listed in Panel 15 should be met.

Diet:

• During rehabilitation the child has been fed five or more times each day. At home, the child should be fed at least three times per day. Adjustment to this change in frequency of feeding should take place under supervision before discharge if possible. This is done by gradually reducing the supplemental feeds of F−100 until they end, and adding or increasing the mixed diet until the child is eating as he or she will at home.

Follow−up after discharge

Although follow−up of all recovered malnourished children may be impossible in an emergency situation, there should be some attempt to signal recovered children to local health or nutrition workers or community−level child care providers if they exist. It should be made known to everyone who cares for such children that they are at increased risk of recurrence of malnutrition and of serious illness. If there are any community−level support structures for parents of such children, they should be mobilized and supported. Children should be weighed and measured regularly after discharge (after one week, two weeks, one month, three months, and six months, if possible).

Failure to respond to treatment

General principles

When the guidelines in this annex are followed, a severely malnourished child should show definite improvement within a few days and should continue to improve thereafter. Failure to achieve initial improvement at an expected rate is termed primary failure to respond; whereas deterioration of the child’s condition, when a satisfactory response has been established, is termed secondary failure to respond.

A child who meets any of the criteria in Panel 16a should be diagnosed as failure to respond. When this diagnosis is made it is essential that practices in the TFC be carefully reviewed and that the child be thoroughly re−evaluated. The objective is to identify the cause of failure to respond and to correct the problem by making specific changes in practices in the unit or in the child’s treatment. Treatment should never be changed blindly; this is more likely to harm than to help the child. The most frequent causes of failure to respond are listed in Panel 16b and should be examined if there are significant numbers of cases of failure to respond.
Problems with preparing or giving food

Standard hygiene practices should be used when storing, preparing and handling food in the kitchen of the TFC, and these should be monitored regularly. Workers should wash their hands with soap after defecation and before handling food. Foods should be thoroughly cooked and served promptly. Ensure that sufficient time is taken with the feeding of each child and that there are enough staff, day and night, for this task. Remember that feeding a malnourished child takes more time and patience than does feeding a normal child. Allowing an average of 15 minutes to feed one child, and assuming food is given every 3 hours, means one person is needed day and night to feed 12 children.

Problems of individual children

Feeding:

- **Is enough food being given?** Food requirements may need to be recalculated and corrected, and the amounts of food being taken by the child should be checked and recorded accurately. Parents should be asked about food given at home to children in the day−care unit.

- **Are nutrients well absorbed?**
  - Children with otherwise good appetite and good intake who do not gain weight may have unrecognized pancreatic insufficiency and fat malabsorption. If the stool contains visible fat, addition of pancreatic enzyme granules to the child’s food may be helpful.

- **Are sufficient vitamins and minerals being given?**
  - Ensure vitamin and mineral mixes are added in appropriate quantities to children’s food every day.

- **Is the child ruminating?**
  - Rumination is a severe form of self−stimulation that occurs in up to 10 per cent of severely malnourished, emotionally impaired children. Ruminating children regurgitate food from the stomach into the mouth, and then spit much of it out. They often smell of vomit, and may have vomit−stained clothes or bedding. They are often unusually alert and suspicious, may make stereotyped chewing movements, and do not appear distressed by vomiting. Rumination is best treated by staff members who have experience with this problem and give special attention to the child.

Learning from failure

Accurate records should be kept of all children with failure to respond and of all deaths. These should include, at least, the child’s age, sex, date of admission, date and time of death, principal diagnoses, weight−for−length on admission, apparent cause of death and any recognized deficiencies in the care given. Periodic review of these records can help to identify areas where case management practices should be carefully examined and improved. For example, death in the first two days is often due to hypoglycaemia, unrecognized or mismanaged septic shock, or other serious infection, whereas death after day 2 is often due to heart failure.

Malnutrition in adolescents and adults

Malnutrition in adults and adolescents is generally less common than in young children but is a danger signal when it occurs. If its prevalence is significant, it may indicate impending famine. The physiological consequences of malnutrition in adults and adolescents include impaired resistance to infection and, for
women, poor outcomes of pregnancy.

Classification of malnutrition

Adults (over 18 years):

- **Body mass index.** The objective is to assess the degree of ‘thinness’, using body mass index (BMI) as the indicator. BMI is defined as body weight (in kg) divided by the square of height (in metres); i.e. wt/ ht$^2$. Panel 17 gives BMI cut–off values for defining grades of malnutrition in adults.

- When an adult cannot stand, **demi–span** should be measured. This is the distance from the middle of the sternal notch to the tip of the middle finger with the arm held out horizontally to the side. Both sides should be measured. If there is a discrepancy, the measurements should be repeated and the longest one taken. Height (metres) can then be calculated as follows:

  \[ \text{height} = [0.73 \times (2 \times \text{demi–span})] + 0.43. \]  
  BMI is then computed from the calculated height and measured weight.

- **Oedema.**

  Examine the ankles and lower legs for pitting oedema. If symmetrical oedema is present, its cause must be determined. In addition to malnutrition, causes in adults include pre–eclampsia in pregnant women, heavy proteinuria (nephrotic syndrome), nephritis, acute filariasis (the limb is hot and painful), heart failure, and wet beriberi. Non–nutritional causes of oedema can readily be identified by the history, physical examination and urinalysis. Adults with a BMI of <16 or with nutritional oedema should be admitted for supervised care.

Adolescents (12–18 years):

- BMI standards have not been developed for persons in this age group, but normal values are available for weight–for–age and height–for–age (see WHO or NCHS documents). Using these, weight–for–height can be determined by plotting the weight against the height–age, rather than the actual age. If the adolescent is <70% (3 SD) of the median or has nutritional oedema, severe malnutrition should be diagnosed, and referral for treatment should be made.

Further guidance


Panels

Panel 1 – Time–Frame for Management of the Child with Severe Malnutrition
Panel 2 – Feeding Equipment for a TFC Serving 100 Severely Malnourished Children

<table>
<thead>
<tr>
<th>Items provided by OXFAM on the basis of field experience</th>
<th>Nearest Supply Division equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 large cooking pots (50 litres) with lids</td>
<td>20–390–00</td>
</tr>
<tr>
<td>2 wooden paddles for stirring food</td>
<td></td>
</tr>
<tr>
<td>120 cups</td>
<td>20–690–00</td>
</tr>
<tr>
<td>120 bowls</td>
<td>20–514–00</td>
</tr>
<tr>
<td>300 teaspoons (50 metal, 250 plastic)</td>
<td>20–867–00</td>
</tr>
<tr>
<td>2 measuring jugs (2 litres)</td>
<td>02–610–00 &amp; 20–225–00</td>
</tr>
<tr>
<td>2 scoops</td>
<td></td>
</tr>
<tr>
<td>2 ladles</td>
<td>20–655–00</td>
</tr>
<tr>
<td>2 whisks</td>
<td></td>
</tr>
<tr>
<td>1 food scale</td>
<td>05–500–00</td>
</tr>
<tr>
<td>1 alarm clock</td>
<td>46–210–00</td>
</tr>
<tr>
<td>1 scrubbing brush</td>
<td></td>
</tr>
<tr>
<td>2 large plastic jerry cans</td>
<td>50–071–00</td>
</tr>
<tr>
<td>4 buckets with lids</td>
<td>02–638–00</td>
</tr>
<tr>
<td>2 hurricane lamps</td>
<td>50–280–00</td>
</tr>
<tr>
<td>12 candles with matches</td>
<td></td>
</tr>
<tr>
<td>1 torch with 4 batteries</td>
<td>06–300–00 &amp; 18–022–12</td>
</tr>
<tr>
<td>500 water purifying tablets</td>
<td>15–522–02</td>
</tr>
<tr>
<td>50 naso–gastric tubes</td>
<td>03–730–00 &amp; 03–735–00</td>
</tr>
<tr>
<td>5 syringes</td>
<td>07–856–74</td>
</tr>
<tr>
<td>adhesive tape</td>
<td>05–010–50</td>
</tr>
</tbody>
</table>

Equipment for weighing and measuring children:

hanging scales, weight–for–height charts, height stick, length board, tape measures, arm circumference tapes, stationery, pocket calculator
### Panel 3 – Sample Monthly Report Format for a Therapeutic Feeding Centre (TFC)

#### SAMPLE MONTHLY REPORT FORMAT FOR A THERAPEUTIC FEEDING CENTRE (TFC)

**Therapeutic Feeding Centre**

<table>
<thead>
<tr>
<th>Category</th>
<th>No. enrolled end last montha</th>
<th>New admissions this monthb</th>
<th>Transfers to SFP: −2 s.d. WfHc</th>
<th>Drop-outs this monthd</th>
<th>Total end this month</th>
<th>No. who since last report:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 5–59 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lost weight Did not gain weight</td>
</tr>
<tr>
<td>&lt;−3 s.d. WfH (no oedema)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With oedema</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>totals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Number of children attending each day:**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|---|
|   |   |   |   |   |   |   |   |   |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |  / |   |   |   |

*Put slash (/) in boxes on days when SFP is closed*

**Remarks:**

**Signature:**

---

### Panel 4 – Classification of Malnutrition

#### CLASSIFICATION OF MALNUTRITION

<table>
<thead>
<tr>
<th>Symmetrical oedema</th>
<th>Well–Nourished</th>
<th>Mild Malnutrition</th>
<th>Moderate Malnutrition</th>
<th>Severe Malnutrition (type)(^1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>yes (Oedematous malnutrition)(^2)</td>
</tr>
<tr>
<td>Weight–for–height</td>
<td>90 to 120%</td>
<td>80 to 89%</td>
<td>70 to 79%</td>
<td>&lt;70% (−3 Z) (severe wasting)</td>
</tr>
<tr>
<td>(+2 to −1 Z)</td>
<td>(−1 to −2 Z)</td>
<td>(−2 to −3 Z)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height–for–age</td>
<td>95 to 100%</td>
<td>90 to 94%</td>
<td>85 to 89%</td>
<td>&lt;85% (−3 Z) (severe stunting)</td>
</tr>
<tr>
<td>(+2 to −1 Z)</td>
<td>(−1 to −2 Z)</td>
<td>(−2 to −3 Z)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) The diagnoses are not mutually exclusive. A child can have severe wasting and oedematous malnutrition, or severe wasting and severe stunting, etc.

\(^2\) This corresponds to the definition of ‘kwashiorkor” and “marasmic kwashiorkor” in older classifications. However, to avoid confusion with the clinical syndrome of kwashiorkor, which includes other features, the term ‘oedematous malnutrition’ is preferred.
### IMPORTANT POINTS IN THE HISTORY AND PHYSICAL

#### History:
- Usual diet before recent illness
- Breast-feeding history
- Food and fluids taken in past few days
- Recent sinking of eyes
- Duration, frequency and quality of vomiting or diarrhoea
- Time when urine was last passed
- Contact with measles or tuberculosis
- Any deaths of siblings
- Birth weight
- Milestones reached (sitting, standing, etc.)
- Immunizations

#### Physical examination:
- Weight, and length or height
- Oedema
- Enlarged or tender liver, jaundice
- Abdominal distension, bowel sounds, abdominal ‘splash’
- Severe pallor
- Signs of circulatory collapse: cold hands and feet, weak radial pulse, diminished consciousness
- Temperature: hypothermia or fever
- Thirst
- Eyes: corneal lesions of vitamin A deficiency
- Ears, mouth, throat: evidence of infection
- Skin: infection or purpura
- Respiratory rate and type of respiration: pneumonia, heart failure
- Appearance of faeces
Specimen or test | Result and significance
--- | ---
Tests that may be useful:
e | To confirm hypoglycemia: glucose <3 mmol/l or <54 mg/dl
blood smear | To detect malaria parasites
haemoglobin or packed cell volume | Very severe anemia is haemoglobin <40 g/l or PCV <12%
urine for pus cells; dip stick for infection; culture and sensitivity | Any bacteria on microscopy or more than 10 leucocytes per high power field means infection
faeces | Observe for blood (dysentery). Microscopy for cysts or trophozoites of Giardia
chest X−ray | Pneumonia causes less shadowing than in well−nourished children. Vascular engorgement suggests heart failure. Bones may show rickets or rib fracture
skin test for TB | Often negative in children with TB or previous BCG
Tests that have little value:
serum proteins | Not useful in management; they may guide prognosis
HIV test | Should not be done routinely; if done, results should be confidential
electrolytes | Rarely helpful and may lead to inappropriate therapy

Panel 7 – Compared Features of Dehydration and Septic Shock in the Severely Malnourished Child

<table>
<thead>
<tr>
<th>Some dehydration</th>
<th>Severe dehydration</th>
<th>Incipient septic shock</th>
<th>Developed septic shock</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watery diarrhoea</td>
<td>yes</td>
<td>yes</td>
<td>yes or no&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Mental state</td>
<td>restless, irritable&lt;sup&gt;b&lt;/sup&gt;</td>
<td>lethargy, coma</td>
<td>apathetic</td>
</tr>
<tr>
<td>Sunken eyes</td>
<td>yes&lt;sup&gt;b,c&lt;/sup&gt;</td>
<td>yes&lt;sup&gt;b,c&lt;/sup&gt;</td>
<td>no&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Thirsty</td>
<td>drinks eagerly</td>
<td>drinks poorly</td>
<td>no</td>
</tr>
<tr>
<td>Cool hands/feet</td>
<td>no&lt;sup&gt;b&lt;/sup&gt;</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Weak or absent</td>
<td>no&lt;sup&gt;c&lt;/sup&gt;</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Radial pulse</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Urine flow</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td>yes, no</td>
<td>yes or no</td>
<td>yes or no&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hypothermia</td>
<td>no</td>
<td>no</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> Signs that may be useful in diagnosing septic shock
<sup>b</sup> Signs that may be useful in diagnosing dehydration
<sup>c</sup> If confirmed as recent by the mother

Panel 8 – Composition of Concentrated Solution of Mineral Mix

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>MMOL</th>
<th>Grams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potassium chloride</td>
<td>74.6</td>
<td>89.5</td>
</tr>
<tr>
<td>Tripotassium citrate</td>
<td>324.0</td>
<td>32.4</td>
</tr>
<tr>
<td>Magnesium citrate</td>
<td>203.0</td>
<td>30.5</td>
</tr>
</tbody>
</table>
### Panel 9 – Amount of Diet to Give at Each Feed to Achieve 100 Kcal/Kg per Day

#### AMOUNT OF DIET TO GIVE AT EACH FEED TO ACHIEVE 100 KCAL/KG PER DAY

<table>
<thead>
<tr>
<th>Weight of child (kg)</th>
<th>Volume of F−75 for each feed (ml)</th>
<th>Volume of F−100 for each feed (ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>every hour (24 feeds)</td>
<td>every 2h (12 feeds)</td>
</tr>
<tr>
<td>2.0</td>
<td>11 21 32</td>
<td>16 24 32</td>
</tr>
<tr>
<td>2.5</td>
<td>13 27 40</td>
<td>20 30 40</td>
</tr>
<tr>
<td>3.0</td>
<td>16 32 48</td>
<td>24 36 48</td>
</tr>
<tr>
<td>3.5</td>
<td>19 37 56</td>
<td>28 42 56</td>
</tr>
<tr>
<td>4.0</td>
<td>21 43 64</td>
<td>32 48 64</td>
</tr>
<tr>
<td>4.5</td>
<td>24 48 72</td>
<td>36 54 72</td>
</tr>
<tr>
<td>5.0</td>
<td>27 53 80</td>
<td>40 60 80</td>
</tr>
<tr>
<td>5.5</td>
<td>29 59 88</td>
<td>44 66 88</td>
</tr>
<tr>
<td>6.0</td>
<td>32 64 96</td>
<td>48 72 96</td>
</tr>
<tr>
<td>6.5</td>
<td>35 69 104</td>
<td>52 78 104</td>
</tr>
<tr>
<td>7.0</td>
<td>37 75 112</td>
<td>56 84 112</td>
</tr>
<tr>
<td>7.5</td>
<td>40 80 120</td>
<td>60 90 120</td>
</tr>
<tr>
<td>8.0</td>
<td>43 85 128</td>
<td>64 96 128</td>
</tr>
<tr>
<td>8.5</td>
<td>45 91 136</td>
<td>68 102 136</td>
</tr>
<tr>
<td>9.0</td>
<td>48 96 144</td>
<td>72 108 144</td>
</tr>
<tr>
<td>9.5</td>
<td>51 101 152</td>
<td>76 114 152</td>
</tr>
<tr>
<td>10.0</td>
<td>53 107 160</td>
<td>80 120 160</td>
</tr>
</tbody>
</table>

Example 1: If a 7.0kg child is given f−75 every hour, each feed should be 37ml.

Example 2: If a 4.5kg child is given f−100 every 3 hours, each feed should be 54ml.

### Panel 10 – Composition of Liquid Diets

#### COMPOSITION OF LIQUID DIETS

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>F–75 Diet amount</th>
<th>Ingredient</th>
<th>F–100 Diet amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>dried skim milk</td>
<td>25g</td>
<td>dried skim milk</td>
<td>80g</td>
</tr>
<tr>
<td>cane sugar</td>
<td>60g</td>
<td>cane sugar</td>
<td>50g</td>
</tr>
<tr>
<td>oil</td>
<td>20g</td>
<td>oil</td>
<td>60g</td>
</tr>
<tr>
<td>rice flour or other cereal flour</td>
<td>60g</td>
<td>mineral mix</td>
<td>20ml</td>
</tr>
<tr>
<td>mineral mix</td>
<td>20ml</td>
<td>vitamin mix</td>
<td>see Panel 11</td>
</tr>
<tr>
<td>vitamin mix</td>
<td>see Panel 11</td>
<td>water</td>
<td>to make 1,000ml</td>
</tr>
<tr>
<td>water</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Mix milk powder, sugar, oil and flour in 700ml water. Boil 5–7 min. Cool, dissolve mineral mix and vitamins, and add water to make 1,000ml.
### Panel 11 – Composition of Liquid Diets

<table>
<thead>
<tr>
<th>Vitamin Mix</th>
<th>Mineral Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamin</td>
<td>Amount to be added to one litre of liquid diet:</td>
</tr>
<tr>
<td>Water soluble:</td>
<td></td>
</tr>
<tr>
<td>thiamin</td>
<td>0.7mg</td>
</tr>
<tr>
<td>riboflavin</td>
<td>2.0mg</td>
</tr>
<tr>
<td>niacin</td>
<td>10.0mg</td>
</tr>
<tr>
<td>pyridoxine</td>
<td>0.7mg</td>
</tr>
<tr>
<td>cobalamin</td>
<td>1.0mg</td>
</tr>
<tr>
<td>folac acid</td>
<td>0.35mg</td>
</tr>
<tr>
<td>ascorbic acid</td>
<td>100.0mg</td>
</tr>
<tr>
<td>pantothenic acid</td>
<td>3.0mg</td>
</tr>
<tr>
<td>biotin</td>
<td>100.0mg</td>
</tr>
<tr>
<td>Fat soluble:</td>
<td></td>
</tr>
<tr>
<td>retinol</td>
<td>1.5mg</td>
</tr>
<tr>
<td>calciferol</td>
<td>30.0mg</td>
</tr>
<tr>
<td>tocopherol</td>
<td>22.0mg</td>
</tr>
<tr>
<td>vitamin K</td>
<td>40.0mg</td>
</tr>
</tbody>
</table>

### Panel 12 – Desirable Daily Nutrient Intake During – Initial Phase Of Treatment

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>Amount (per kg body weight)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water</td>
<td>120–140ml</td>
</tr>
<tr>
<td>Energy</td>
<td>420kj (100kcal)</td>
</tr>
<tr>
<td>Protein</td>
<td>1−2g</td>
</tr>
<tr>
<td>Electrolytes:</td>
<td></td>
</tr>
<tr>
<td>sodium</td>
<td>&lt;1.0 mmol (&lt;23mg)</td>
</tr>
<tr>
<td>potassium</td>
<td>&gt;4.0mmol (&gt;160mg)</td>
</tr>
<tr>
<td>magnesium</td>
<td>&gt;0.6mmol (&gt;10mg)</td>
</tr>
<tr>
<td>phosphorous</td>
<td>2.0mmol (60mg)</td>
</tr>
<tr>
<td></td>
<td>2.0mmol (80mg)</td>
</tr>
<tr>
<td>Trace minerals:</td>
<td></td>
</tr>
<tr>
<td>zinc</td>
<td>30mmol (2.0mg)</td>
</tr>
<tr>
<td>copper</td>
<td>4.5mmol (0.3mg)</td>
</tr>
<tr>
<td>selenium</td>
<td>60mmol (4.7mg)</td>
</tr>
<tr>
<td>iodine</td>
<td>100mmol (12mg)</td>
</tr>
<tr>
<td>Water soluble vitamins:</td>
<td></td>
</tr>
<tr>
<td>thiamin</td>
<td>&gt;70mg</td>
</tr>
<tr>
<td>riboflavin</td>
<td>&gt;200mg</td>
</tr>
<tr>
<td>niacin</td>
<td>&gt;1,000mg</td>
</tr>
<tr>
<td>pyridoxin</td>
<td>&gt;70mg</td>
</tr>
<tr>
<td>cobalamin</td>
<td>&gt;100mg</td>
</tr>
<tr>
<td>folic acid</td>
<td>&gt;100mg</td>
</tr>
<tr>
<td>ascorbic acid</td>
<td>&gt;10mg</td>
</tr>
<tr>
<td>pantothenic acid</td>
<td>&gt;300mg</td>
</tr>
<tr>
<td>biotin</td>
<td>&gt;10mg</td>
</tr>
</tbody>
</table>
Fat soluble vitamins:

<table>
<thead>
<tr>
<th>Vitamin</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>retinol</td>
<td>150mg</td>
</tr>
<tr>
<td>calciferol</td>
<td>3mg</td>
</tr>
<tr>
<td>tocopherol</td>
<td>2.2mg</td>
</tr>
<tr>
<td>vitamin K</td>
<td>4mg</td>
</tr>
</tbody>
</table>

Panel 13 – Treatment of Clinical Vitamin A Deficiency for Children 12 Months or Older

| TREATMENT OF CLINICAL VITAMIN A DEFICIENCY FOR CHILDREN 12 MONTHS OR OLDER¹ |
|-------------------------------|------------------|-------------------|-----------------|
|                               | Retinyl Palmitrate | Retinyl Acetate   | International Units |
| Days 1 and 2                  | 55mg IM or 110mg oral | 33mg IM or 66mg oral | 100,000IU IM or 200,000 IU oral |
| Discharge                     | 110mg oral        | 66mg oral         | 200,000 IU oral   |

¹Children 6–11 months should be given only half the dose shown, and those less than 6 months should be given one quarter of the dose.

Panel 14 – Criteria for Transfer to a Day Care Unit

<table>
<thead>
<tr>
<th>CRITERIA FOR TRANSFER TO A DAY CARE UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>· Eating well</td>
</tr>
<tr>
<td>· Mental state has improved: smiles, responds to stimuli, interested in surroundings</td>
</tr>
<tr>
<td>· Sits, crawls, stands, or walks (depending on age)</td>
</tr>
<tr>
<td>· Normal temperature</td>
</tr>
<tr>
<td>· No vomiting or diarrhoea</td>
</tr>
<tr>
<td>· No oedema</td>
</tr>
<tr>
<td>· Gaining weight: &gt;5 g/kg body weight per day for 3 successive days</td>
</tr>
<tr>
<td>· Middle of the night feed no longer needed</td>
</tr>
<tr>
<td>· No problem that requires treatment in hospital</td>
</tr>
</tbody>
</table>

Panel 15 – Criteria for Discharge Care

<table>
<thead>
<tr>
<th>CRITERIA FOR DISCHARGE CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
</tr>
<tr>
<td>☐ Weight–for–height at least 90% (−1 SD) of NCHS median value on 2 weighings</td>
</tr>
<tr>
<td>☐ Eating an adequate amount of a nutritious diet that the mother can prepare at home</td>
</tr>
<tr>
<td>☐ Gaining weight at a normal or increased rate</td>
</tr>
<tr>
<td>☐ All vitamin and mineral deficiencies have been treated</td>
</tr>
</tbody>
</table>
All other conditions are adequately treated, including: anaemia, diarrhoea, intestinal parasites, malaria, TB, otitis media

Full immunization has begun

**Mother or Caretaker**

- Knows how to prepare appropriate foods and to feed the child
- Knows how to make toys and stimulate healthy play
- Knows how to give home treatment for diarrhoea, fever, and ARI, and when to get help

**Home**

- There is a willing and able caretaker for the child and someone who can supervise frequent feeding (at least 3 times per day)
- There is a plan for follow-up of the child and support for the mother

---

**Panel 16 – Criteria for “Failure to Respond”**

<table>
<thead>
<tr>
<th>CRITERIA FOR “FAILURE TO RESPOND”</th>
<th>Time after admission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary failure to respond:</strong></td>
<td></td>
</tr>
<tr>
<td>• Fails to regain appetite</td>
<td>By day 4</td>
</tr>
<tr>
<td>• Fails to start to lose oedema</td>
<td>By day 4</td>
</tr>
<tr>
<td>• Oedema still present</td>
<td>By day 10</td>
</tr>
<tr>
<td>• Fails to gain weight at more than 5g/kg/d</td>
<td>By day 10</td>
</tr>
<tr>
<td><strong>Secondary failure to respond:</strong></td>
<td></td>
</tr>
<tr>
<td>• Fails to gain at least 5g/kg per day for 3 successive days</td>
<td>During rehabilitation</td>
</tr>
</tbody>
</table>

**Panel 16 (b).**

**USUAL CAUSES OF FAILURE TO RESPOND**

**Problems with the treatment facility:**
- Poor environment for malnourished children
- Insufficient or poorly trained staff
- Inaccurate weighing machines
- Food prepared or given incorrectly

**Problems of individual children:**
- Insufficient food given
- Vitamin or mineral deficiency
- Malabsorption
- Rumination
- Infection, especially diarrhoea, dysentery, otitis media, pneumonia, tuberculosis, urinary infection, malaria, HIV/AIDS
- Serious underlying disease

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**Panel 17 – Classification of Malnutrition in Adults by Body Mass Index**

| CLASSIFICATION OF MALNUTRITION IN ADULTS BY BODY MASS INDEX |
### Chapter 2 – Annex 2: Assessing Nutritional Status

#### Objectives

The possible objectives of a survey of nutritional status in emergencies include:

- to diagnose the problem and determine its extent;
- to identify groups at highest risk, e.g. nomads, displaced groups, specific age groups;
- to estimate the numbers of people needing assistance; and
- to act as a baseline to monitor the impact of interventions or the response to an improving or worsening situation.

This annex provides basic standardized procedures for making rapid but reliable estimates of nutritional status in emergencies. It is a summary of a field guide on assessing nutritional status in emergencies, developed by a group of experts from WHO, UNICEF, UNHCR, Centers for Disease Control (CDC) Atlanta, FAO, Save the Children Fund (SCF) UK, and representatives from countries of the Eastern Mediterranean Region, and thus its contents have the broad consensus of these groups.

#### Planning the survey

Information on nutritional status will be of practical use only within the framework of the general situation in the country or region in which the emergency occurs. Existing knowledge on demography, mortality and morbidity, previous nutritional status, the socio-economic situation, administrative structure, communications, etc., should be collected before embarking on a rapid assessment of nutritional status. This will permit an action-oriented selection of the study population and the planning of appropriate relief, which may not be limited to nutrition. Cooperation with other departments and ministries at an early stage is therefore essential.

Recent data on mortality are especially important for the interpretation of nutritional status and, if they are not available, they may be collected at the time of the nutrition survey.

The population to be assessed may be moving or living in camps, towns or villages, or dispersed in a rural environment. This will have important bearings on the design of the survey and the use of the results. Based on geographic information and available time, decisions will have to be made on the number and composition of survey teams. The type and number of trained, partially trained, or untrained personnel available will determine the amount of training needed and the necessary equipment and transport. Such decisions depend in part on the sample design, which may in turn be constrained by the available resources.

The following checklist is meant to assist in the planning of a survey.

<table>
<thead>
<tr>
<th>Checklist for planning and implementing a survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Which population is to be assessed (country, region, ethnic group, etc.)?</td>
</tr>
<tr>
<td>• What is the smallest unit to be assessed (camp, village, district)?</td>
</tr>
<tr>
<td>• Is there a need to analyse subgroups (by sex, age, ethnicity)?</td>
</tr>
<tr>
<td>• Which sampling methods will be used (systematic, cluster)?</td>
</tr>
</tbody>
</table>
• Which age groups (6−59 months, 60−100 cm, 60−110 cm)?
• What will be the sample size?
• Which indicators will be used (weight−for−height, oedema)?
• What personnel, equipment, transport, number of teams, and resources will be needed?
• Workload: How many children (clusters) per day, per team?
• Has a training schedule for field workers been prepared?
• Who will conduct the training? Where?
• Who will supervise the teams during the survey?
• Will data be analysed by hand and/or by computer?
• Are computers and operators available?
• Who is responsible for the logistics (e.g. transport, equipment, accommodation, information for target population, etc.)?
• Who is responsible for report writing and interpretation of findings (who is the target audience, what is the target date, etc.)?
• Who is responsible for taking action on the report’s findings?

Selection of survey subjects

In a simplified rapid field assessment, nutritional status is usually measured only in children between the ages of 6 and 59 months. Frequently, children in this age group will be the first to show signs of under nutrition. They are generally highly vulnerable and in times of nutritional crisis may show increased morbidity and mortality. Children under 6 months of age (or about 60 to 65 cm long if age is not known), apart from being more difficult to measure, are often still breastfed and therefore satisfactorily nourished. The upper limit of 59 months corresponds to approximately 100 to 110 cm in height of the reference population.

Because children in many developing countries are significantly stunted, a sample with the 110 cm cut−off will often include many children over five years of age and a correspondingly smaller proportion of the younger and most vulnerable children below two years. To maintain an adequate proportion of the younger children, it is recommended to use 100 cm as the cut off point. At this stage, no distinction is made between sexes.

In food emergencies, older children, pregnant and lactating women, the elderly, and the disabled may also be considered high−risk groups. They are generally not weighed and measured because there are no valid references for most of these groups. Since the status of young children reflects that of the general population, relief measures should also be extended to the other vulnerable groups if not to the general population.

It should be noted that if many older children and adults are affected, the Body Mass Index (BMI = kg/m 2) can be used for an estimate in adults. The WHO expert committee on ‘Physical Status: The Use and Interpretation of Anthropometry’ described the condition of low BMI as ‘thinness’, with the following three grades:

• Grade 1: BMI 17.018.49 (mild thinness)
• Grade 2: BMI 16.016.99 (moderate thinness)
• Grade 3: BMI < 16 (severe thinness)
Selecting the sample

If an estimate of malnutrition is needed for a relatively small group of children, it is best to examine all of them. In a small population of, say, 2,000 to 3,000 people of whom 18 to 20 per cent may be children below five years of age all eligible children should be examined. In larger populations it is usually easier to examine and analyse only a sample of children and to draw conclusions on the probable proportion of malnourished children in the total population.

The first step is to define the population for which the estimate is needed. This study population is also called the sampling universe. The sampling universe may be the child population of one or several refugee camps, of a province, or of a country. The estimate will only be valid for the sampling universe as a whole. If separate estimates are needed for ethnic or geographic subgroups or other subdivisions of the sampling universe, each of them must be treated as a separate universe for which a separate sample must be constructed. Therefore, the smallest subdivision on which information is sought should be determined at the outset.

For emergency assessments several types of sampling are available:

- **Simple random sampling**: The children are chosen at random from a list of all eligible children in the sampling universe. This is the ideal procedure but usually not practicable in an emergency.

- **Systematic random sampling**: Children are selected systematically, say every tenth child, from a list of all households. Alternatively, if the average number of preschool children per household is known, a sample of households, say every 10th house or tent, may be taken systematically, and all eligible children in these houses are examined.

- **Cluster sampling**: Clusters or groups of households are selected from a list or from a map of all clusters; in each selected cluster a predetermined number of children is selected at random, systematically or sequentially.

- **Stratified sampling**: The universe is stratified by certain characteristics thought to influence nutritional status: age, sex, social or ethnic group, environment. Each stratum is an independent universe from which samples may be drawn by one of the above-listed methods. Stratified sampling is also used where several areas or camps are to be surveyed and each of them is to be viewed separately. It can be used with simple random sampling, systematic random sampling or cluster sampling.

The choice of sampling methods depends mainly upon practical conditions. In settlements and camps, systematic random sampling is the method of choice; in a scattered population, cluster sampling may have to be the choice. It must be borne in mind that in cluster sampling, the sample size needs to be twice that of systematic random sampling.

**Systematic random sampling**

Systematic random sampling is particularly recommended where the population is concentrated in an organized or structured urban setting or in a refugee camp, and where the total number of households is less than 10,000. Knowledge is required on: (1) the number of households, (2) the average number of children in the 6 months to 100 cm (five years) group per household, (3) the total population or number of people in the universe.

The recommended sample size is 450 children. This number will ensure with a probability of 95 percent that the estimated prevalence will be within plus or minus five prevalence percent of the true prevalence irrespective of the level of prevalence. A safety margin of about 10 percent is included. If children are included up to 110 cm instead of 100 cm, the sample size should be increased to 500 children.

In practice, in camps as well as in permanent settlements, the sampling unit is the household or dwelling. Taking into account an average household size of A persons and an average proportion P of children of the right age/height in a population, the number of households needed to yield the required number of eligible children is calculated as follows:
• Number of households to be visited = \( \frac{450}{A \times P} \)

• For example, if the average household size is 6 persons and the proportion of children under 5 years is 0.15 or 15\%, then \( \frac{450}{(6 \times 0.15)} = 500 \) households should be visited.

• If the sampling universe consists of 9,000 households, the sampling interval equals \( \frac{9,000}{500} = 18 \). Thus every 18th household is to be visited.

Over- or under-estimation of people, of households, or of the proportion of children will result in a sample that is either too small or too large. This will cause unnecessary delays and loss in precision. Estimates should therefore be as accurate as possible.

Estimates can be improved by doing a rapid count of households when planning the survey. If the number of persons in a camp or a village is known, the number of households can be estimated from a subsample of, say, 30 house-holds; by dividing the total population of these households by 30, an average of the number of persons per house-hold is obtained.

If the percentage of children in the appropriate 6 months to 100 cm group is overestimated, fewer households will be surveyed and the resulting sample of children will be too small. It is therefore better to underestimate than to overestimate the percentage. Information on household composition may be available from previous census data of the camp or town residents.

In most developing countries, about 15 per cent of the population will be in the required age-length group. However, in emergencies such as famines or wars, this figure may be considerably lower or higher, because infants and children may have died or many adult men may be absent.

**Cluster sampling**

In cluster sampling the sample children are not spread randomly over the population but are lumped into randomly selected ‘clusters’. It is the usual method for large populations and populations spread over a large area for which only rough estimates of the number of people are available. It may also be an advantage in large or newly established camps where numbers and ages of people are still incompletely known. However, the sample size needed to obtain the same precision is about twice that of a systematic random sample, i.e. 900 children.

This sample size ensures with a probability of 95 per cent that the estimated prevalence will be within plus or minus 5 prevalence per cent of the true prevalence, irrespective of the value of the prevalence, and assuming a correction factor of two (the “design effect”) for cluster sampling. For reliable results, it is important to examine not less than 30 clusters and not less than a total of 900 children.

For a rapid assessment in an emergency, when there is little time for preparatory work, the following sampling procedure is recommended:

• The area of interest is divided on a map into sections of about equal size, following, as far as possible, the existing geographic or administrative boundaries. Each section should have at least 300 inhabitants.

• A systematic sample of 30 clusters is drawn from a list of all sections and their population estimates.

• The total number of clusters is divided by 30 to obtain the cluster interval \( k \) starting from a randomly selected cluster on the list, every \( k \)th cluster is selected.

• For example, suppose there is a total number of 183 sections. This is divided by 30 to obtain the cluster interval (183 divided by 30 = 6.1). Starting from a randomly drawn section, say section no. 15, every sixth section down the list is chosen until the 30 survey sections, the clusters, are selected. During the survey, the team starts at the centre of the cluster and chooses a direction (for example by spinning a pen on a book). The survey is started at the nearest dwelling in that direction, moving to successive houses until 30 children have been examined. At each dwelling, all eligible children should be examined.
The traditional community–based cluster sampling based on proportional sampling with a list of communities and their populations may not always be feasible in emergencies. If multiple areas or camps are to be surveyed, the most efficient approach may well be to treat each area as a stratum and to conduct systematic random sampling in each.

**Important considerations in sampling**

Every effort should be made to obtain the needed data on all children in the sample. For example, in cluster sampling all 30 children from each cluster must be seen and all eligible children in the cluster must be given equal probability of being selected.

Although random numbers are used to select sampling sites, households and starting points, the selection procedure is never haphazard.

Samples must be selected by a rigid and defined methodology. Once the sample selection has begun, the procedure should not be changed or modified. Children must be selected for examination only by using the selected sampling procedure. Any exception will bias the estimates.

In subsequent surveys to measure changes over time, the same methodology should be used to ensure comparable results.

Only children in the households or family groups selected by the sampling procedure should be examined.

All eligible children between six months and 100 cm, in each selected household or family grouping should be examined. If necessary, team members must actively search for eligible but absent children, even if a dwelling is temporarily empty, and include such children in the survey.

If a central examination site is chosen, great care must be taken to ensure that all the selected children arrive at the site. During preliminary household visits, children may be numbered sequentially and the number given to the mother on a piece of paper to bring with the child to the examination site. Missing children can then be sought.

In spite of its apparently greater simplicity, in a population that is concentrated in a relatively small area, cluster sampling has no advantage over stratified or systematic sampling with its smaller sample size. Therefore, the sampling method should be carefully chosen.

For each survey, the method of sample selection should be documented in writing and included in the report of survey results.

**Survey methodology**

**Methods**

The assessment of nutritional status is based on simple anthropometric data and limited to children of preschool age, who serve to represent the general population. The data to be collected are weight, height, sex, oedema and age (if available). The assessment is limited to protein–energy malnutrition without attempting to assess other nutritional deficiencies. No further variables should be added without considering the additional workload and delay involved.

Weight–for–height is recommended as the main or only indicator of malnutrition by most manuals and guidelines issued by UN agencies, governments and non–governmental organizations. It is robust, is independent of age for children, has an internationally accepted reference population, and its interpretation is based on wide experience in many parts of the world.

The indicator is formed from weight and height measurements by comparing the weight of each child to the distribution of weights of reference children of the same height. For each height, the weights of the reference
children are distributed as an approximately normal bell-shaped curve (Panel 1), with most weights arranged around the middle of the curve, which is the mean or median of the reference weights. In order to determine the position of a measured weight in relation to the distribution of the reference weights, the distance in kilograms from the median of the reference curve is determined and expressed as the number of standard deviations of that distribution. This is called a standard deviation (SD) or Z-score. The standard deviation of a distribution is a measure of the width of the distribution around the mean. Standard deviation scores of children of different heights and sexes are biologically equivalent and can be compared, pooled or treated statistically.

By convention, children with a weight–for–height of less than 2 SD. or 2 Z-scores below the median of the reference are called seriously or acutely malnourished. This limit is called the cut off point. In the normal distribution of the reference population, 2.5 per cent of the children are below 2 SD. by definition. There is a 1 in 43 chance that a child with weight–for–height below this point is not malnourished but is thin for other reasons. The percentage of 2.5 is considered a baseline indicating that there is no malnutrition in a population.

A second cut off point, 3 Z-scores (or 3 SD) below the median, is often used when screening malnourished children for therapeutic feeding and treatment of infections. At this cut off, there is no baseline, since at this level all children are critically ill and severely malnourished (see Panel 6).

It should also be noted that oedema is additional weight. Children with oedema are malnourished even though their weight may not fall below 2 Z-scores. Therefore oedema must be checked for and noted on the data sheet.

**Measuring techniques and recording**

**Weight:** A suitable instrument for weighing a child is a 25 kg hanging spring scale marked out in steps of 0.1 kg. After weighing pants are attached to the lower hook of the scale, the instrument is adjusted to zero. The weighing pants are then taken off and handed to the weigher. The child is freed from all heavy clothing and the weighing pants are put on the child. The child is then suspended from the weighing scale by the handles of the pants. The child should hang freely. The weight is read to the nearest 0.1 kg with the scale at eye level. The measurer reads the value out loud, the assistant repeats it and writes it down on the recording form.

UNICEF is currently testing an electronic scale (UNISCALE, price about US $100) for weighing young children that has the advantage of allowing the child to be weighed in the arms of his/her mother. When the mother stays on the scale and momentarily hands the child to a neighbour or health worker, the scale automatically subtracts out the weight of the child and flashes it on an electronic screen. UNISCALE has been used in a number of emergency situations and enables weighing of large numbers of children to be conducted much more rapidly than with hanging scales.

Every morning the scale should be checked against a known weight of 10 kg or less and adjusted, if necessary. If the reading is incorrect, and the scale cannot be adjusted, the springs of the scale must be changed or the scale replaced. Portable electrical scales marked in 100 g steps are also becoming available but need further testing for sturdiness under field conditions. Such a scale can be set to zero while an adult stands on it. The adult then holds the child while both are weighed, which reduces the child’s distress. Local beam balances might also be used if accurate to 100 g.

**Height:** Children up to two years (23 months or 85 cm) of age are measured on a horizontal measuring board. Shoes should be removed. The child is placed gently onto the board, the soles of the feet flat against the fixed vertical part, the head near the cursor or moving part. The child should lie straight in the middle of the board, looking directly up.

The assistant holds the feet firmly against the footboard and places one hand on the knees of the child, while the measurer gently holds the child’s head, places the cursor against the crown of the head and reads out the length to the nearest 0.1 cm.

Children over two years of age (or over 85 cm) are usually measured standing on a horizontal surface against a vertical measuring device. The assistant makes sure that the child stands straight, with the heels, knees and shoulders against the wall, while the cursor is lowered onto the crown of the head, compressing the hair. The height is read out as before, to the nearest 0.1 cm.
An easier way to measure height consists in taking the ‘lying down’ or recumbent length of all children from 6 months to 100 cm (59 months). This method is preferred by many field workers, as it avoids scaring children and making them struggle. The recumbent length is on average 0.5 cm greater than the standing height. Although the difference is of no importance for the individual child, the effect on the prevalence in a population is significant, increasing the prevalence of malnutrition by 2 to 7 percent for prevalences between 5 and 50 per cent. This may have to be taken into account when comparing prevalences.

**Age:** An assessment of the ages of the children is important for two reasons: (1) malnutrition is often most marked between 6 and 18 months, which is why the age groups below and above two years of age should be considered separately for relief action; (2) if the height of older children is measured when they are standing, the dividing line is two years. When birth records or other documents are available, the birth date should be entered on the recording form for later computation of the exact age, or when the age is known by the mother it should be recorded in months in the appropriate space. However, in emergencies, it is often very difficult to obtain ages. *If the age is uncertain, no effort should be made to estimate it* (for example by a local calendar). Instead, lengths and heights should be used to group children by approximate age: 60 to 84.9 cm is equivalent to six months to two years; 85 to 100 cm is equivalent to 24 to 59 months (85 to 110 cm if population is not stunted).

**Oedema:** Oedema is the presence of abnormally large amounts of fluid in the intercellular tissue. It is the key clinical sign of a severe form of protein–energy malnutrition carrying a very high mortality rate in young children. To diagnose oedema, moderate thumb pressure is applied to the back of the foot or the ankle for a few seconds. If there is oedema, an impression remains for some time where the oedema fluid has been pressed out of the tissue. Only if *both feet* show oedema is this recorded. Cases with oedema are separated from the rest during the analysis and are counted as severe malnutrition. A prevalence of oedema of 1 or 2 per cent is a sign of widespread malnutrition. Children with oedema are severely ill and need immediate treatment.

**Dehydration:** In some circumstances, recording of dehydration may be indicated. This may be important where diarrhoeal disease plays a major role and may especially affect children with evidence of wasting and weight–for–height below 2 Z–scores. The physical signs include loose skin, easy ‘tenting’ of skin and very dry mucous membranes. These children will need immediate attention. Similarly, it may be desirable to record current diarrhoea in certain surveys.

**Data recording**

In the field, findings are recorded on special data sheets, which can be either a separate form for each child or a summary form on which the data of a number of children are combined. Individual forms are useful in examination stations in camps, where children may move from station to station and heights and weights may be taken by different persons. Summary sheets are useful for mobile teams going from house to house; there is less accumulation of paper, and transmission of the forms for central analysis is easier.

If computers are used for the analysis, an exact copy of the data entry screen may be printed as a field questionnaire if the Epi–Info software mentioned below is used. In addition to the location (district or town area, camp), the cluster number and the examination date, the form should also contain data on weight, height, sex (and age or birth date, if available), and if needed, for example for follow–up, an identification (name or number) for each child. Spaces to record the presence or absence of oedema, dehydration and diarrhoea can also be provided.

If data analysis is to be carried out by hand in the field, forms with appropriate spaces for the results will have to be prepared. Examples of data collection forms and of a data entry screen printout are given in Panels 2, 3 and 4. There is room for 15 data entries on the form, so two forms would accommodate a cluster. If you make your own data collection form, it is a good idea to limit yourself to 30 entries per sheet for easier compilation.

**Training and supervision**

The quality of the survey results depends largely on adequate training and supervision.
Training includes defining the role and task of each member of a survey team, procedures to select the households, interviewing techniques, completion and coding of the survey form, and carrying out anthropometric measurements.

In general, an adequate training programme consists of three phases:

- **Classroom–based orientation**: Demonstration of and practice in using the questionnaires and measuring heights and weights of children. All procedures should be practiced by all team members.

- **Field practice session**: Survey procedures are carried out by all team members together in an actual community to standardize procedures and organize activities, and to give team members the opportunity to practise measuring children in a survey environment. After the practise session, performances are reviewed and discussed.

- **Survey starting phase**: In the starting phase of the actual survey, two to three teams survey together the first eight to ten households and then discuss and comment on each performance. This phase should be carried out slowly to ensure that all teams follow the same practise.

There are usually two levels of supervision: the survey manager and the team leaders. The overall supervisor (team) who conducts the training and manages the overall survey may be seen as the manager(s) of the survey. In addition, each survey team should have a designated team leader who is responsible for household selection, quality of measurements, and proper completion of forms.

The overall supervisor(s) needs to rotate to the different teams during the survey to monitor progress, help solve problems, and maintain comparability among the teams. Periodically, supervisors and team leaders should repeat routine measurements and record these double measurements to help maintain the quality of anthropometric techniques.

**Data analysis**

**Analysis of anthropometric data**

The analysis of survey results can be done in the field by hand tabulation or, if a portable computer (laptop or notebook computer) is available, by entering the data into it. In either case, the weight–for–height curves of the NCHS/CDC/WHO reference are needed for the interpretation of individual weight–for–height findings. For hand tabulation, Panel 4 gives the −2 Z-score weight for height cut off point for the classification of malnutrition in the field.

**Data analysis by hand**

For the immediate decisions needed in an emergency, data analysis by hand using Panel 5 will yield sufficient information. This table is for both sexes combined.

The weight of each child is checked against the −2 and −3 Z–score cut off points given in Panel 6 for the height or length measured for the individual child. If the weight is below the −2 Z–score cut off, tick the box on the survey form as a case of malnutrition. Children with weights–for–height below −3 Z–scores are in critical condition and need immediate attention by health personnel. At the bottom of each sheet, the subtotal of all cases of malnutrition including those with oedema is computed. The number of cases divided by the total number of children on the sheet and multiplied by 100 gives the prevalence for the sheet.

After the first analysis by hand, the data forms must be sent to a computer facility of central survey headquarters for further analysis by computer. If local facilities are available, field data may also be entered into a computer on the spot for immediate analysis.
Data analysis by computer

For computer-based operations in the field, data processing with *EpiInfo*, *Epinut* or *Anthro* software can calculate individual weight-for-height Z-scores, which may be further analysed later.

*Epi−Info* software may be purchased for US $35 from USA Inc., 2075 A West Park Place, Stone Mountain, GA 30087, USA. It can be used for many types of epidemiological investigation. Since *Epi−Info* is public-domain software, it can also be copied from any existing user.

*Epi−Info, Epinut and Anthro* may also be obtained without cost from: Division of Nutrition (MS K25), Centers for Disease Control, Atlanta, GA 30333, USA, or from the World Health Organization, Nutrition Unit, Avenue Appia, CH1211 Geneva 27, Switzerland, or through local WHO offices.

If the *Epi−Info* programme is used for the entry of survey results, the computed Z-scores can be saved as a new variable as each record is being entered. The exact procedure is detailed in the anthropometry section of the *Epi−Info* manual. The program automatically computes weight-for-height and Z-scores, which can then be saved to the data file after checking for errors, such as extreme values. A recent version of *Epi−Info* (version 6), integrates *Epinut* into the *Epi−Info* software and has a more accessible anthropometry module than earlier versions.

In general, a weight-for-height Z-score above +4 or below -4 is likely to be an error rather than a true observation. If such values cannot be verified by re-measurement or as entry error, they should be counted as missing values. The percentage of such 'likely errors' should not exceed 2% of the sample. High error values are indicative of poor measurement and/or data entry procedures. However, in extreme situations with large proportions of severely malnourished children (below 3 Z-scores), the lower limit for acceptable values may have to be dropped to a Z-score of 5.

Recommended format for data analysis

Prevalence of acute malnutrition

The prevalence of serious or acute malnutrition is the sum of the prevalence of children with weight-for-height below 2 Z-scores and the prevalence of oedema cases with weight-for-height of 2 Z-scores or more. In most cases the prevalence of oedema is only a small fraction and contributes little to the total prevalence, but in disasters with famine-like conditions the prevalence of oedema may be high and must be taken into account.

Mean Z-scores and standard deviation

The use of computer software allows the calculation of a Z-score for each child. The mean Z-score and the distribution of Z-scores of weight-for-height, i.e. the standard deviation of the Z-scores, provide useful information in addition to the prevalence below the cut off point. The mean Z-score of a well-nourished child population should be near zero with a standard deviation of 1.0. In malnourished populations the mean Z-score will be negative, below 0.5 Z-scores. This indicates that not only has the prevalence of weight-for-height below 2 Z-scores increased, but the whole distribution has shifted to the left.

The standard deviation of the weight-for-height Z-score is also important. If the standard deviation of the Z-score is significantly lower than 1.0 while the mean Z-score is significantly lower than 1.0, one may suspect that the most affected children have already died. Conversely, a high standard deviation of the weight-for-height Z-score is probably due to errors in the data but may produce a wrong high or low prevalence. In all cases of inconsistency between mean Z-score and prevalence, an investigation into the field situation and the survey methods is needed.

*Epi−Info* and other software will produce tables of frequencies for Z-score classes of 0.5 Z-score intervals.
and graphs of frequency distributions. A graphic representation of the difference between the distribution of the survey population and that of the reference, as in Panel 5, underlines the fact that the survey population as a whole is affected by the emergency and that relief measures should be directed at the total population rather than exclusively covering the fraction with extreme anthropometric values.

Prevalences and mean Z-scores are most conveniently presented in one table. With the sample size of 450 recommended in this manual, a breakdown into two age or height groups can be made. This may reveal that a problem exists only or mainly in one of the two groups. Although dividing the sample in this fashion will lead to a loss in precision, major differences between the groups will still show. This is useful for the detection of specific causes or for targeting limited resources.

**Interpreting results and reporting findings**

As stated earlier, in emergencies, estimates of malnutrition are based on the distribution of weight–for–height with a cut off at 2 Z-scores. Prevalence of low weight–for–height as a direct measure of abnormal thinness in a preschool child population indicates serious health and nutritional conditions.

**Interpretation of results**

In order to simplify the interpretation of results and as an aid in briefing officials, the value judgements given below have been developed for children 6–59 months of age or 60–100 cm in length. This classification underlines the public health importance of prevalence levels that are sometimes considered too low to require corrective action.

<table>
<thead>
<tr>
<th>PERCENTAGE WfH &lt; 2 Z–SCORES</th>
<th>INTERPRETATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5</td>
<td>Acceptable</td>
</tr>
<tr>
<td>5–9.9</td>
<td>Poor</td>
</tr>
<tr>
<td>10–14.9</td>
<td>Serious</td>
</tr>
<tr>
<td>&gt; 15</td>
<td>Critical</td>
</tr>
</tbody>
</table>

However, in the same populations, much higher prevalences are often found for narrower age ranges, for example between 1 and 2 years or below 36 months.

Moreover, in already malnourished populations or in a very severe famine of some duration, much higher prevalences may be seen, which, for the purpose of setting relief priorities, might need additional classifications.

On the other hand, if prevalences are lower than could be expected from the severity of the emergency, the possibility must be considered that many children have already died. Remember, children with a weight–for–height below 2 Z-scores are in a serious acute condition. Children with a Z-score below 3 are in a life–threatening state.

**Report outline**

The report on the results of the survey should be brief but include all available relevant information on the overall situation.

Panel 7 provides a proposed format for the report. Sections 1–3, discussing area, type of emergency and main changes brought about by the emergency, can be written before the survey actually takes place, as they form the framework and rationale for the nutritional status survey. Sections 4–7 can be written when the survey is designed, leaving only section 8–10 to be written after the survey.
Further guidance


Panels

Panel 1 – Approximately normal weight–for–height reference curve

![Reference Z-scores graph](source: WHO)

Panel 2 – Summary Data Sheet for Hand Analysis

<table>
<thead>
<tr>
<th>SUMMARY DATA SHEET FOR HAND ANALYSIS</th>
</tr>
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<td>Cluster or locality:</td>
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<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Mean weight</th>
<th>Mean height</th>
</tr>
</thead>
</table>

Number of children <-2Z–scores or/and oedema
Panel 4 – Summary Tables for Data Analysis

### SUMMARY TABLES FOR DATA ANALYSIS

**a) Minimum table for hand analysis**

<table>
<thead>
<tr>
<th>Age/Length</th>
<th>Number of subjects</th>
<th>Prevalence WfH, $\leq -2$ Z-scores</th>
<th>$%$ with oedema</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;85 cm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 85 cm</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**b) More detailed table**

<table>
<thead>
<tr>
<th>Age/length</th>
<th>Number of subjects</th>
<th>Prevalence WfH</th>
<th>Total WfH prevalence</th>
<th>SD of WfH</th>
<th>Mean of WfH</th>
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<tr>
<td></td>
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<td>$&lt;-3$ Z-scores</td>
<td>$\leq -2$ Z-scores</td>
<td>$&gt;-3$ Z-scores</td>
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<td>Total</td>
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</table>

(source: WHO Field Guide on Rapid Nutritional Assessment in Emergencies)
Panel 6 – Z-Score Reference Table of Weight-for-Height (length)

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<th>Length</th>
<th>Weight Kg</th>
<th>Length $^2$</th>
<th>Weight Kg</th>
<th>Length $^2$</th>
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<td></td>
</tr>
</tbody>
</table>

Length below 85 cm; height from 85 cm, or 2 years and above. If you use this table with children above 85 cm who were measured lying down, you must correct the prevalence (see page 21 and Annex 4)

Panel 7 – Proposed Outline for Survey Report

PROPOSED OUTLINE FOR SURVEY REPORT

1. Area where the survey was held:
   • Size and geographical character

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Chapter 2 – Annex 3: Assessing Household Food Security

Objective

To help determine the present and near term food access of households, the objective is to identify interventions to improve household food security and to determine whether a food aid programme is necessary.

Household food security in emergencies

Household food security is the capacity of households to have access to adequate food for all members at all times of the year. The extent to which an emergency adversely affects household food security depends on three major factors:

• the impact of the emergency on households’ usual means of acquiring food (i.e. breakdown of food production systems, markets, income earning opportunities, opportunities for barter,
social networks, etc).

• the impact of the emergency on the households’ capacity to prepare or store available food; and

• the quality or acceptability of available food during the emergency.

In addition, an emergency may cause a breakdown of households themselves, leading to food acquisition problems for individuals.

An assessment of these factors is a matter of first priority in an emergency. Results of such an assessment will help determine the present and near–term food access of households, help to identify measures to reinforce the capacity of households (if intact) to ensure their own food security and help to determine whether (and what type of) food aid programme is necessary.

It should be clear, however, that access to food is only one of three underlying major causes of malnutrition, along with care and health, and there must be an understanding of the relative importance of each in order to identify the best intervention strategies. The household food security assessment tool presented below, therefore, should be used in conjunction with the assessment tools covering health and care presented elsewhere in the handbook.

**General household food security assessment tool**

The following assessment tool, Panel 1, is meant for early stages of an emergency in cases where households/ families are intact enough to carry on basic activities related to food access (production, purchase, preparation, gathering, etc.). Elements of it may be used for later–stage assessment and reassessment.

The focus is on information pertinent to the household level. It is assumed that more macro–level meteorological, demographic and economic information will be consulted as necessary in addition to the assessment suggested below.

The assessment tool should be used with the recognition that basic elements of food security assessment may have already been done by other agencies. In that case, the tools can be used as a guide to review various kinds of existing information and to verify areas of interagency collaboration.

**Possible UNICEF inputs**

While UNICEF’s concern is with the needs of children and women, it is important that the focus of the assessment of food needs remains on the household or family if households are intact. UNICEF, therefore, has a role in overall assessment of household food needs and not simply of those of children.

**Further guidance**


### Panels

#### Panel 1 – Assessment

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Likely information source/methodology</th>
<th>Analysis</th>
<th>Possible action(s)</th>
</tr>
</thead>
</table>
| 1. What are the principal means of access to food for HHs other than food aid and their relative importance. How have these changed since the crisis? | • observation  
• rapid survey of HHs in various circumstances  
• existing data | Rough estimate of % of HH food before and after crisis derived from:  
• own production, including gathering, hunting, fishing, milk and meat from animals  
• purchase/barter  
• gifts, aid. | Begin to identify barriers to food access in current situation and past experience that can inform actions. |
| 2. What were the major income sources before the emergency, and how have these changed | • observation  
• rapid survey of HHs in various circumstances  
• existing data (especially budget surveys) | Estimate importance before and after crisis of:  
• Wage labor  
• crop, livestock sales  
• trade, barter  
• other commerce  
• gifts, aid. | Identify barriers to income generation and activities that may remove them. Identify partners who may be able to help in this area. |
<p>| 3. What are the main barriers to food access of the various occupational and social groups affected by the emergency, and can they be removed? | Observation and, if necessary, rapid survey to classify HHs roughly by occupation if relevant. Also information from two previous questions. | Make rough classification of most important barriers by occupational (or other relevant) groupings of HHs. Attention to the local availability of food is important here. | With results of two previous questions, identify most important barriers to food access (including barriers to income for groups relying on purchased food) and groups suffering |</p>
<table>
<thead>
<tr>
<th></th>
<th>4. What food stocks and savings of cash or marketable assets are available to HHs affected by the crisis?</th>
<th>• observation</th>
<th>• rapid survey of HHs in various circumstances</th>
<th>Assess approx. quantities of: • food • livestock • cash • marketable assets • durables, including items carried by refugees, IDPs.</th>
<th>Rough estimate of food quantities available and value of disposable assets that might be turned into food, latter depending on the other basic needs and customary asset sales. This estimate becomes a factor in answering to no. 5 below. [This to be done jointly with WFP]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5. Are resources in food or cash needed beyond what is already in the area to ensure HH food security for 3–4 months?</td>
<td>Info used in 1–4 above.</td>
<td>Make enough estimate of food needs based on demographics make–up of affected population. Energy can be used as the adequacy criterion at this stage. (See question 11 below.)</td>
<td>With appropriate partners [see WFP MOUE] agree on estimate of food needs, composition of food assistance possible, etc.</td>
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<td></td>
<td>6. What are the coping mechanisms that have appeared or been intensified</td>
<td>• observation</td>
<td>• rapid survey of HHs in various circumstances</td>
<td>Attention to such factors as unusual asset sales, forced small commerce (gathering and selling of wood, e.g.), reliance on gathered foods, unusual loans, etc., forced migration, etc.</td>
<td>Identify coping that appears to be effective and practical means to support it. (See also next question.)</td>
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<tr>
<td></td>
<td>7. Are coping activities burdening women unduly or changing HH composition?</td>
<td>• observation</td>
<td>• rapid survey of HHs in various circumstances</td>
<td>Try to reduce reliance on coping mechanisms that compromise health of some HH members or integrity of the HH members or integrity of the HH. Reinforce those that do not pose these problems.</td>
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<td></td>
<td>8. Is there a seasonal aspect to food access? (e.g. Is a harvest expected soon? Are some products likely to be scarce soon?)</td>
<td>• existing data</td>
<td>• key informants</td>
<td>Rough drawing of usual seasonal pattern of food production or availability may be useful.</td>
<td>Modify projected food needs accordingly.</td>
</tr>
<tr>
<td></td>
<td>9. Are there factors other than seasonal food access that are likely to change in the short term</td>
<td>• observation</td>
<td>• key</td>
<td>Attention to such factors as peace agreements, opening or closing of roads or markets, development</td>
<td>Modify projected food needs accordingly.</td>
</tr>
<tr>
<td>and may affect food access to HHs?</td>
<td>information programmes or initiative</td>
<td>Rapid and rough assessment of access to cooking fuel, utensils, pots, etc. and necessary storage compared to need.</td>
<td>In consultation with WFP, estimate shortfall and ensure provision.</td>
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<tr>
<td>10. How have usual means of food preparation and storage been affected by the emergency?</td>
<td>• observation</td>
<td>Rapid assessment of HHs in various circumstances</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>• rapid survey of HHs in various circumstances</td>
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<tr>
<td>11. Is available food adequate to cover micro–nutrient needs of the affected population?</td>
<td>• food composition table</td>
<td>Rapid and rough assessment of micro–nutrient content of likely diet compared to need. Attention to vulnerable groups.</td>
<td>Identify likely risks of micro–nutrient deficiency and high–risk groups. Ensure supplementation of fortification with pre–mix.</td>
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<tr>
<td></td>
<td>• basic daily requirements for principal MNs</td>
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<td></td>
<td>• nutrition workers</td>
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**Chapter 2 – Annex 4: Infant Feeding in Emergencies: Policy, Strategy & Practice**


**Contents**

*Target audience (uses)*

**Introduction**

All users of this document.

Policy and Strategy Statement

Agencies who wish to revise/establish a policy statement in this area. (Can be used as guidance for field programme managers).

Activities to Implement Strategy

Agency personnel involved in the implementation of policy.

Fact Sheet

Non–technical agency personnel e.g. desk officers and fundraisers. Health and community workers in emergencies.

Advertorial

General public (Can be placed in newspapers/magazines in donor countries during large scale appeals).

Triage for Decision Making

Field workers (to appropriately target infant feeding advice and interventions).

Prioritisation of Alternatives for Feeding

Field workers, programme planners and managers (to guide Infants programme implementation and allow preparation of appropriate stocks).

Cup Feeding

Field workers (to guide practice).

Monitoring & Evaluation

Programme planners and managers
Introduction

Purpose

The purpose of the UK Infant Feeding in Emergencies Group (IFEG) was to build on existing knowledge and to formulate a coherent, appropriate and widely acceptable policy and strategy statement on infant feeding in emergencies for humanitarian agencies. IFEG also attempted to address some of the problems and knowledge gaps around this subject and to identify practical tools to assist agencies in the implementation of policy.

Participants and process

IFEG comprised individuals and representatives from a wide range of agencies concerned to promote positive and appropriate infant feeding practices in emergency and relief settings (see Annex VII). Baby Milk Action, the UK component of the International Baby Food Action Network (IBFAN), initiated the process which resulted in the series of meetings held between September 1996 and December 1997.

Context

IFEG meetings followed on from a meeting organised by IBFAN in Geneva in 1995. Although it was recognised that there would sometimes be a need for the provision of small amounts of infant formula in emergency situations, the report of the Geneva meeting\footnote{1} identified the need to protect mothers and children in emergencies where breastfeeding may be undermined by indiscriminate distribution of infant formula and other breastmilk substitutes. Recommendations from the Geneva meeting included the continuation of the process of awareness raising and information exchange among interested groups, particularly NGOs involved in emergencies, at national level.


This document

This document is a collage of the main outputs of the UK IFEG meetings. The contents of this document are intended to add to and support other work in this area. Original work carried out by members of IFEG appears in the body of this document, and other reference information appears as annexes. Different sections of this document are targeted at different audiences, as indicated on the Contents page.

A draft version of this document was also disseminated at the international meeting hosted by IBFAN in Split, Croatia in October 1998 and is now available to other interested agencies and individuals.

Background

The International Code

The International Code of Marketing of Breast-milk Substitutes was adopted by the World Health Assembly (the policy-setting body of WHO) in 1981. The aim of the Code is to ‘contribute to the provision of safe and
adequate nutrition for infants, by the protection and promotion of breast-feeding, and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution”. Footnote 2


Since 1981, the World Health Assembly has passed a number of Resolutions all of which have equal status with the Code. The Code and subsequent Resolutions aim to ensure that information on infant feeding is not influenced by commercial considerations, and that marketing practices do not undermine breastfeeding. The Code and Resolutions are therefore important safeguards for health workers, parents and infants, including those in emergency and relief situations. IBFAN groups are mandated to monitor the marketing activities of companies that produce breastmilk substitutes.

Why is infant feeding an important issue in emergencies?

The benefits of breastfeeding have been amply demonstrated under non-emergency conditions. Until the age of about six months, an infant who is exclusively breastfed on demand has all the nourishment s/he requires to grow and develop normally, as well as considerable protection against infection. In the conditions characteristic of most emergencies, breastfeeding becomes even more important for infant nutrition and health. The resources needed for safe artificial feeding – such as water, fuel and adequate quantities of appropriate breastmilk substitutes – are usually scarce in emergencies. Artificial feeding in these circumstances increases the risk of diarrhoeal diseases and malnutrition, which in turn substantially increase the risk of infant death.

In an emergency, the adequate supply of appropriate food is obviously of fundamental importance. A common belief is that in emergencies it is infants who are at greatest risk of becoming malnourished – but this is not true of breastfed infants. The ability to breastfeed is robust, even in the face of constraints such as reduced maternal dietary intake and psychological stress. There may, however, be occasions where breastfeeding is not an option for some infants and alternatives are required (see Prioritisation of alternatives for feeding infants, page 20).

Emergencies: the changing scene

The number of refugees and displaced people worldwide is growing, and a high proportion of them are vulnerable mothers and infants. The importance of infant feeding issues in such populations has been highlighted by the recent spate of humanitarian emergencies in middle-income countries, where breastfeeding rates have been in decline for a number of years. In communities where a ‘bottle-feeding culture’ has taken root prior to the onset of a humanitarian crisis, it is extremely important – but often quite difficult – to protect and support breastfeeding under emergency conditions.

Another feature of the changing humanitarian scene is the emergence of new agencies, sometimes started spontaneously by concerned individuals or small groups. Some of these smaller agencies are active in collecting and delivering donated goods as relief to emergency-affected populations (usually in countries of Central and Eastern Europe and the Former Soviet Union, which are relatively easy to reach by road from Western Europe). Despite their enthusiasm and commitment, some of these newer and smaller agencies lack the in-depth understanding and specialist skills required to deal effectively with infant feeding issues in these settings.

Over the years, there have been numerous incidences of infant formulas and bottles being donated by companies to relief agencies for use as emergency aid. The motives for making and accepting such donations – which might range from the desire to open up new markets, to the wish to improve public relations, to simple altruism – are perhaps less important than their effect on infant feeding practices and infant health in recipient communities.

Although there has been little formal assessment of the impact of infant formula donations, many health workers are concerned about negative effects on breastfeeding. Donations that carry brand names and/or inappropriate images and/or inappropriate information can undermine breastfeeding and create demand for
expensive breastmilk substitutes. Fundraising appeals by NGOs can also have adverse effects; if appeals use images of starving babies and suggest that mothers cannot breastfeed, inaccurate public perceptions of infant feeding issues may be reinforced.

The need to develop policy

Major United Nations agencies and well established non-governmental organisations have developed their own policies relating to the distribution of powdered milk and breastmilk substitutes. However, many other agencies – especially the newer and smaller ones – may be unaware of the relevant issues and the need for such policies. They may measure their effectiveness only in terms of the volume of food they have delivered, without attempting to assess the longer-term impact of their activities on the health of the recipient population.

As agencies become more aware of the harm that can be caused by the inappropriate use of artificial formula, they are likely to see the need for an explicit policy on infant feeding, and may require guidance to develop and implement it. The remainder of this document is one source of such guidance. Other information sources on this topic can be found in Annex VIII.

A Suggested Policy and Strategy Statement on Infant Feeding in Emergencies

This policy statement is intended to give guidance to those who work in humanitarian emergencies, whether they are expatriate or local staff, health professionals or support staff. The statement may be used by organisations or individuals.

This statement is concerned with infant nutrition, particularly of those infants aged less than 6 months during humanitarian emergencies. It does not cover complementary feeding, nor does it cover the identification and management of severely malnourished infants in emergencies.

POLICY

Our goal is to ensure that the nutritional, health and psychological needs of infants and young children and their mothers in emergency affected populations are addressed in such a way as to:

• reduce the risk of morbidity and mortality in infancy and early childhood; and

• obtain maximum health benefits from the use of resources available to humanitarian agencies, indigenous health services and affected households.

3. An infant is a child aged below 12 months. For the purpose of this paper, however, where prime concern is for the period of an infant’s life when milk feeding is essential, the term infantis limited to those aged below 6 months only. This age coincides with the period for which exclusive breastfeeding is recommended by the World Health Assembly (WHA) in Resolution 47.5, 1994.

Our guiding principles in achieving this goal are:

1. promotion of infant feeding practice that is in the best interests of the child, mother and other carers, based on the best available scientific evidence;

2. recognition of the biological superiority of breastfeeding over artificial feeding, especially in situations of inadequate sanitation and poor health service provision, and of the physiological robustness of lactation (for example, with regard to the effects of malnutrition and stress);

3. recognition of mothers’ rights to make and implement decisions regarding infant feeding, together with acknowledgement of the actual and potential role of other members of the family and the wider society in influencing these decisions and their implementation; and
4. compliance with the International Code of Marketing of Breast−milk Substitutes and subsequent World Health Assembly Resolutions (the Code), and the Innocenti Declaration.

4. Any food being marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not suitable for that purpose (Article 3, International Code of Marketing of Breast−milk Substitutes. WHO, 1981). This includes infant formula, follow up milks, teas, juices, water and other baby foods when marketed as breastmilk substitutes.

In order to achieve our goal in a manner consistent with these guiding principles, we have devised the following strategy.

STRATEGY

What follows is not a menu from which to make selections, but a strategy to be regarded and implemented in its entirety. The three strategic priorities indicated below are all necessary to the achievement of the goals as stated above, and they are all equally important.

(1) Ensure that any action is based on an adequate understanding of the factors affecting infant feeding practice in that particular situation.

This will require thorough assessment and careful analysis of the situation to identify key factors including: pre−emergency infant feeding knowledge and practice; current practice; knowledge and practice on the part of maternity care givers and providers of maternal and child health care; the extent and nature of commercial promotion of breastmilk substitutes; access to breastmilk substitutes (pre−emergency and currently). The assessment should be conducted in close liaison with: local communities, NGO networks, national support groups and emergency committees.

(2) Protect, support and promote breastfeeding and eliminate practices which undermine breastfeeding, by:

a. raising awareness, increasing knowledge and engendering supportive attitudes across all sections of the humanitarian community − donors, governments, UN organisations, NGOs and local groups alike, as well as in the emergency affected population;

b. improving the capacity of national health staff and international aid workers to provide mothers and families with accurate information, advice and effective support in choosing and using an appropriate infant feeding method;

c. ensuring maternity care practice consonant with the UNICEF/WHO Baby Friendly Hospital Initiative’s Ten Steps to Successful Breastfeeding (see Annex II);

d. raising awareness and improving knowledge of the Code, subsequent WHA Resolutions (the Code) and status of national legislation regarding the marketing of breastmilk substitutes, amongst health workers and aid workers;

e. monitoring field−level compliance with the Code, subsequent WHA Resolutions and national legislation, and reporting violations to the designated lead agency on nutrition/health or to IBFAN.

(3) Minimise the dangers of artificial feeding to infants and their families, by:

a. facilitating the acquisition of a regular and sufficient supply of suitable breastmilk substitute by parents/guardians of artificially−fed infants, without undermining breastfeeding;

b. facilitating the hygienic preparation of artificial feeds by parents/guardians of artificially−fed infants. In every case, this would include strongly discouraging the use of feeding bottles;

c. improving the ability of health services to effectively manage the adverse effects of artificial feeding, especially the increased incidence of severe diarrhoea and respiratory infections in
Many agencies advocate a policy of supporting and protecting breastfeeding in emergency and non−emergency situations. However, some recent emergency experiences have highlighted tensions between policy and practice with regard to infant feeding and have demonstrated how policy makers and planners may occasionally need to be better informed by practical circumstances and problem analysis.

Emergency contexts continuously change, creating new sets of circumstances which can challenge efforts to support and protect breastfeeding. High endemic levels of HIV infection, large numbers of unaccompanied minors and a high prevalence of bottle feeding in some emergency settings can create enormous dilemmas for aid workers about which feeding strategy should be supported. There is a need to clarify best practice for aid workers which is in keeping with policy and strategy statements. There is also a need to develop clear prescriptive guidelines. It was beyond the scope of these meetings to develop such guidelines. However, participants endorsed guidelines produced by Kathy Carter of Oxfam (see abstract below), and also recognised the value of the WHO Guiding Principles for Infant Feeding in Emergencies (see Annex VIII).

There are a number of different activities broadly outlined in the strategy paper which can be undertaken in order to facilitate the implementation of policy. This section of the document presents practical information which will support the implementation of the IFEG strategy. Depending on the type of agency or the position of the individual these activities will differ widely. For example, practice for an advocacy group may be the dissemination of information to the general public or to targeted groups. The activities of NGOs to translate policy into practice are carried out on a number of different levels, such as training for general or technical staff and specific training for staff working in the field. All of these practices or activities should be seen as belonging to a wider group whose emphasis and focus will change depending on profession, position and organisation mandates.

The Infant Feeding in Emergencies Group (IFEG) has produced supporting material intended for practical use for each of the main points outlined in the strategy paper.

### IFEG Strategy Paper, p7, point 1

(1) Ensure that any action is based on an adequate understanding of the factors affecting infant feeding practice in that particular situation. This will require thorough assessment and careful analysis of the situation to identify key factors including: pre−emergency infant feeding knowledge and practice; current practice; knowledge and practice on the part of maternity care givers and providers of maternal and child health care; the extent and nature of commercial promotion; access to breastmilk substitutes (pre−emergency and currently).

<table>
<thead>
<tr>
<th>IFEG activity</th>
<th>a) To support and refer to <em>Feeding in Emergencies for Infants Under Six Months − Practical Guidelines</em> by Kathy Carter (below).</th>
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</table>

An abstract from:

### a) Feeding in Emergencies for Infants Under Six Months − Practical Guidelines

These guidelines will be of use to health and nutrition personnel in agencies both at headquarters and at field level, particularly in situations where there has been a significant percentage of infants dependent on breastmilk substitutes (BMS) prior to the emergency. An initial discussion of the benefits of breastfeeding and factors which may affect breastfeeding is followed by an emphasis on the practicalities of appropriate intervention in order of priority. There is a comprehensive and detailed guide for the assessment of infant feeding practices in emergencies. Next there is a section on appropriate breastfeeding support covering policies, training, camp planning and management, the new−born, retactation, wet−nurses, milkbanks and breastfeeding promotion. Last is a section on appropriate support for carers of infants using BMS, including requirements for safe BMS feeding and distribution of BMS. A list of key texts is included. Requests for copies of the guidelines and/or comments on its use should be made to Judith Appleton, Emergency Department, Oxfam.

<table>
<thead>
<tr>
<th>IFEG activity</th>
<th>b) To highlight relevant and recent information on HIV and infant feeding and to comment briefly on these.</th>
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</table>
**b) HIV and infant feeding**

In an emergency situation the following information must be taken into account before an appropriate infant feeding strategy is determined:

- assessment of the prevalence of HIV in the affected population using secondary sources (including pre-emergency estimates) and relevant information from health information systems;
- assessment of the knowledge of HIV status: were voluntary counselling and testing facilities available pre-emergency? Are there such services available now?
- relevant policies on infant feeding and HIV, from the host and/or home countries.

Breastfeeding is the optimal way to feed an infant in the majority of circumstances. However, studies to date show that breastfeeding can be a route of HIV transmission; 1 in 7 children born to and breastfed by mothers living with HIV become infected by breastfeeding.

Mothers, health workers and policy makers are faced with a dilemma concerning decisions about infant feeding.

There have been many developments recently regarding HIV and infant feeding. Most importantly, WHO, UNICEF and UNAIDS published three documents:

5. HIV and Infant Feeding: Guidelines for Decision Makers (WHO/FRH/NUT 98.1 UNAIDS/98.3)
6. HIV and Infant Feeding: A Guide for Health Care Managers and Supervisors (WHO/FRH/NUT 98.2 UNAIDS/98.4)
7. A Review of HIV Transmission Through Breastfeeding (WHO/FRH/NUT 98.3 UNAIDS/98.5)

The new guidelines are being piloted in eleven countries around the world. At the same time, a number of research projects are underway examining various aspects of mother-to-child transmission of HIV.

**IFEG wish to make the following points on the subject:**

The guidelines have stimulated a great deal of controversy for a number of reasons, primarily to do with cost, feasibility and appropriateness. They also present a shift in policy by emphasising the use of artificial baby milk for mothers tested and found to be infected with HIV.

Although the guidelines stress the right of mothers to make an informed choice about how to feed their baby (without influence from commercial pressure), there is as yet a great deal about which there is little information. In particular:

- the timing of transmission of the HIV virus through breastmilk;
- the relationship between maternal vitamin A status, HIV viral load in breastmilk, maternal CD4 blood count and risk of transmission;
- the relative risks of artificial feeding and breastfeeding outside a research environment, for infants born to HIV positive mothers in resource-poor contexts;
- the relationship between infant gut development, stomach acidity and virus absorption;
- the relative risk between breastfeeding/wet-nursing and artificial feeding among HIV positive women in emergencies.

Furthermore, the IFEG is concerned that, in resource-poor settings, the preparation of infant formula is not a safe alternative to breastmilk. It is also expensive, even if it is subsidised. UN guidelines emphasise the need to avoid the use of formula milk intended for positive mothers by those who are not infected with HIV or who...
are of unknown status (referred to as ‘spill over’). This is particularly pertinent to emergency situations where very few women, if any, will be aware of their HIV status.

IFEG would like to reiterate the following points:

• breastfeeding is recommended for infants born to women who are HIV negative or of unknown HIV status;

• breastmilk substitutes may be a preferable option for infants born to women infected with HIV who are aware of their positive status. However, for this to be true, the risks arising from artificial feeding must be less than the risks of HIV transmission through breastfeeding;

• the need to protect mothers from becoming infected with HIV, must remain a priority.

The IFEG is concerned that breastmilk substitutes may be inappropriately targeted to infants for whom breastfeeding is still the optimal feeding option. It is essential that in all circumstances the International Code of Marketing of Breastmilk Substitutes and subsequent resolutions are adhered to.

for further information, including comments on the UN Guidelines, contact: Baby Milk Action, Save the Children or the nutrition sections of WHO and UNICEF.

Strategy Paper, p7, point 2a

(2) Protect, support and promote breastfeeding and eliminate practices which undermine breastfeeding, by:

f. raising awareness, increasing knowledge and engendering supportive attitudes across all sections of the humanitarian community − donors, governments, UN organisations, NGOs and local groups alike as well as in the emergency affected population;

IFEG activities

<table>
<thead>
<tr>
<th>IFEG designed two leaflets for specific target groups (see contents page):</th>
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<tbody>
<tr>
<td>d. Fact Sheet (for format suitable for duplication contact the ENN)</td>
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<tr>
<td>e. Advertorial</td>
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</tbody>
</table>

Fact Sheet

Ad Hoc Group on Infant Feeding in Emergencies Fact Sheet

Why is infant feeding an important issue in emergencies?

• nutrition is closely linked to an infant’s health and survival, in the short and long–term;

• a child’s early nutrition will affect his/her later growth, health and mental development;

• infant feeding practice offers the first bonding between mother and baby.

This paper outlines how infant feeding practices in emergencies are an important determinant of health, growth and survival outcomes. In nearly all contexts, breastfeeding is the most beneficial form of feeding for both mother and baby and as such, measures should be taken to protect, promote and support it.

What are the benefits of breastfeeding?

Apart from breastmilk providing a well balanced and complete diet for infants it also has other benefits:

• it protects against disease and infections, in both baby and mother;

• it protects against allergies in babies;
• breastfeeding immediately after birth reduces the risk of maternal haemorrhage;

• exclusive breastfeeding for the first six months of life delays the return of fertility, acting as a natural method of birth spacing;

• it is free, pre-warmed, clean and safe, and immediately ready on demand;

• it is environmentally friendly (requires no fuel, packaging or waste disposal);

• breastfeeding is a sustainable feeding method, giving the mother control.

What are the risks of artificial feeding?

The use of breastmilk substitutes should be discouraged in emergencies because:

• of the increased risk of sickness:

  i) contaminated milk or equipment causes diarrhoea and may lead to malnutrition and death. It is difficult to ensure sterilisation of feeding equipment, especially in an emergency when fuel and cooking utensils may be scarce;

  ii) breastmilk substitute offers no protection against infection or allergies as it does not contain the anti-infective agents that are normally passed form mother to baby in breastmilk;

• it is expensive. If the carer cannot afford to buy breastmilk substitute they may over dilute the formula or use other unsuitable ingredients;

• an uninterrupted supply of breastmilk substitutes cannot be guaranteed in an emergency;

• use of breastmilk substitutes decreases the production of breastmilk, as the mother is receiving less stimulation to produce milk.

What are the principles of good infant feeding?

• at birth, attach baby to breast – the initial colostrum includes important protective agents (immunoglobulins) which enhance gut performance;

• the baby should be positioned well (facing the mother, with the baby’s tummy against its mother’s) and the nipple reaching the back of the baby’s mouth (good attachment), for the suckling reflex to work properly;

• mothers and babies need to learn how to breastfeed, it is not automatic. Relatives, other mothers and health staff can offer important support to new mothers to make sure things go well;

• ensure the baby empties one breast before feeding from the other. The first part of a feed is more watery, quenching thirst; milk becomes gradually richer through the feed, relieving hunger. The more the baby suckles, the more milk is produced;

• breastfeed exclusively – there is no need to give additional fluids, not even water;

• a mother can produce enough milk to feed twins or even triplets – as long as the babies suckle well;

• bottle feeds should not be given as this might confuse the baby’s technique (suckling is not the same as sucking).

What are some common misconceptions about breastfeeding?

There are a number of beliefs, often deeply-held, which are usually misplaced:
“stress prevents mothers from producing milk”

Stress does not necessarily prevent a mother from producing milk.

If a stressful situation prevents a mother from putting her baby to the breast often enough, then her milk supply will be affected. In acute situations the reflex to release milk from the breast may become interrupted temporarily. Otherwise there is no reason why a mother is unable to breastfeed her baby, even in times of stress, in fact at such times breastfeeding can be therapeutic for the mother. Interventions to support breastfeeding mothers, and mitigate stress factors as far as possible, should be encouraged.

“malnourished mothers cannot breastfeed”

Other than in severe cases, malnourished mothers can breastfeed.

Moderate malnutrition has little or no effect on milk production. In fact, the mother will continue to produce milk, even to the detriment of her own wellbeing.

“mother thinks she is not producing enough milk to feed her baby”

A mother does produce enough milk to feed her baby.

The misconception may arise from a mother’s perception (e.g. because a breastfed baby’s growth, especially after the second or third month, is slower compared to the reference population, which is based on the growth of bottle-fed babies); or it may be real. If real, it is probably a result of poor attachment or insufficient suckling. Once corrected, milk supply will improve. Milk production works on a supply-and-demand basis: as long as the baby is put to the breast, is well attached and is allowed to suckle as often as it demands, supply will meet all the baby’s needs.

“stop feeding if the baby has diarrhoea”

Do not stop feeding if the baby has diarrhoea.

Not only does breastmilk contain water to replace losses through diarrhoea, it also supplies important minerals and vitamins to help prevent dehydration, as well as proteins to help strengthen the immune system of the baby. In serious or prolonged cases, rehydration therapy may be required.

“babies need extra fluids such as tea or water”

Breastmilk provides all the fluids a baby needs.

Breastmilk contains the exact amount of water to replace losses through diarrhoea, and other nutrients that a baby needs even in the hottest, driest climates. The fluid in breastmilk is also better absorbed than any other type of fluid.

“only women with large breasts or nipples can breastfeed”

All women can breastfeed.

The key to effective breastfeeding is a good suckling technique – this has nothing to do with breast size or nipple shape or size.

“colostrum should not be given to the new-born”

Colostrum, the first milk, is an important source of early nutrients as well as anti-infective agents. Colostrum also helps improve gut performance.

“once stopped, breastfeeding cannot be re-started”

If a mother stops breastfeeding she can usually restart.

Relactation can take time but is usually possible. The most important factors are:

i) the mother’s willingness to breastfeed again, and

ii) addressing the reasons why she stopped in the first place

The mother should put her baby to the breast regularly (at least every 2–3 hours). Feeding can continue with breastmilk substitutes on a diminishing scale while the relactation process takes place.
Formula milk is an inferior option for babies and their mothers. The optimal food for infants, and the best mode of feeding, is human milk suckled from the breast. Formula is probably the best alternative in the absence of breastmilk.

What can be done for babies not being breastfed?

In certain circumstances, it might be necessary to consider options other than maternal breastfeeding. These situations may include:

- Orphaned babies or babies that have become separated from their parents.
- A very sick mother, who may be unable to breastfeed her infant for some time. In this case it may be necessary to provide other support (see below). It should, however, be the intention to re-start lactation as soon as possible in the mother’s recovery period.
- Mothers who choose not to breastfeed: this may be linked to cultural beliefs or societal norms and pressures.

In such situations, other options might be available and appropriate:

- wet nursing or relactating relatives (i.e. breastfeeding, but not by the mother);
- using pasteurised human milk from banks (which may have been established prior to the emergency);
- using breastmilk substitutes fed with a cup.

Reducing risks associated with artificial feeding

When circumstances arise where breastfeeding is not practised, it is imperative that any measures taken do not undermine the principle that breastfeeding is superior. To this end:

- breastfeeding should continue to be protected, promoted and supported in the wider community;
- ensure an adequate and steady supply of water, fuel and soap for adequate hygiene;
- where possible, generically labelled infant formula should be used, to avoid unnecessary promotion of a commercial brand;
- ensure a steady and adequate supply of formula;
- provide cups rather than bottles since these are easier to keep clean and do not interfere with the baby’s suckling reflex.

The “International Code of Marketing of Breastmilk Substitutes”

The International Code, and subsequent World Health Assembly Resolutions have been adopted by national governments at the World Health Assembly to protect breastfeeding from commercial interests. Manufacturers of breastmilk substitutes have agreed to adhere to the Code. The Code and subsequent Resolutions aim to ensure that the marketing practices of manufacturers do not exploit an emergency situation for commercial gain.

Issues such as advertising (Article 5) and information materials for mothers and health workers (Article 4); labelling of formula packaging (Article 9); and free and low cost supplies in emergencies (WHA Resolution 47.5, 1994) are all covered.

In emergency relief operations, breastfeeding for infants should be protected, promoted and supported. Any donated supplies of breastmilk substitutes (or other products covered by the Code) may be given only under strict conditions (if infant has to be fed with breastmilk).
Substitute); the supply is continued for as long as the infants concerned need it; and the supply is not used as a sales inducement.

(WHA Resolution 47.5, 1994)

For further information see Sokol, 1997.

Advertorial

During emergencies inappropriate and harmful feeding practices are often initiated and supported through donations of infant formula from the general public in response to emergency appeals. Such interventions are often borne out of a genuine though misguided wish to help. The IFEG felt therefore that some attempt should be made at educating the general public. The following advertorial was designed to inform, and provide some guidance to the general public.

We often encounter emergency appeals which highlight images of babies and young children. We may worry that these babies and children will starve unless we (or the agencies appealing for assistance) donate infant formula.

On the other hand, we all know that breastfeeding is best for babies. What many of us do not realise is that this is especially true in emergency situations.

Imagine yourself in a refugee camp, or as a victim of natural disaster. Basic supplies are scarce, there is no clean water, and firewood for cooking is a day’s walk away. Conditions are crowded and dirty; infection is rife. And your baby is screaming to be fed.

Q. How do you make up a bottle of powdered milk properly in this situation?

A. You can’t – but if you’re breastfeeding your baby, you don’t need to! Breastfeeding provides complete nutrition for babies. It is safe, clean and free of charge. It also acts as baby’s first vaccination, helping to protect against infection. This explains why the risk of illness and death is many times higher for artificially fed babies, and why the risk tends to increase in emergencies.

In emergencies, it is more helpful to feed mothers and help them to breastfeed than to send tins of infant formula. Next time you are asked to respond to an emergency appeal, ask about the agency’s policy on infant feeding, and give generously to those that support breastfeeding!

For more information, contact:

| IFEG Strategy Paper, p7, point 2b | (2) Protect, support and promote breastfeeding and eliminate practices which undermine breastfeeding, by:

improving the capacity of national health staff and international aid workers to provide mothers and families with accurate information, advice and effective support in choosing and using an appropriate infant feeding method; |

IFEG has compiled information on training courses for NGO personnel (see annex III).

| IFEG Strategy Paper, p7, point 2e | c. ensuring maternity care practice consonant with the UNICEF/WHO Baby Friendly Hospital Initiative’s Ten Steps to Successful Breastfeeding; |

See annex IV for UNICEF/WHO Baby Friendly Hospital Initiative’s Ten Steps to Successful Breastfeeding.

| IFEG Strategy Paper, p7, point 2c | d. raising awareness and improving knowledge of the WHO Code, subsequent WHA Resolutions and status of national legislation regarding the marketing of breastmilk substitutes, amongst health workers and aid workers; |

The most important parts of the Code and subsequent Resolutions, which relate to infant feeding in emergencies, are outlined at Annex I.
(2) Protect, support and promote breastfeeding and eliminate practices which undermine breastfeeding, by:

- monitoring field-level compliance with the Code, subsequent WHA Resolutions and national legislation, and reporting violations to designated lead agency on nutrition/health or to IBFAN.

**Monitoring practice:** NGOs can help make sure that field practice complies with the Code, by ensuring that all of their staff are aware of the Code and Resolutions, and encouraging field staff to report any instances of violations. The export of branded baby milk with labels in an incorrect language, for example, contravenes EC Directives and Resolutions and should be reported to the appropriate authorities and the European Commission. Another example might be the unregulated and unsupervised distribution of milk products which may undermine breastfeeding. IBFAN monitors compliance with the Code, but does not have a direct role in the delivery of emergency relief assistance.

(3) Minimise the dangers of artificial feeding to infants and their families, by:

- facilitating the acquisition of a regular and sufficient supply of suitable breastmilk substitute by parents/guardians of artificially-fed infants, without undermining breastfeeding.

**IFEG developed tools to assist field workers target breastmilk substitutes appropriately:**

- Feeding Infants Under Six months in Emergencies: A Triage Approach To Decision Making
- Prioritisation of Alternatives for Infant Feeding in Emergencies (as well as emergency stop-gap recipes annex IV)

**Feeding Infants Under Six Months in Emergencies: A Triage Approach To Decision Making**

Until recently, the numbers of children under six months old who have not had access to breastmilk during emergencies have been very few. This remains true for the African context. Yet this small number of children have often posed major difficulties for emergency workers who have lacked a clear framework which allows a comfortable marriage of policy and practice for dealing with this group. In some cases, the existence of a few children who could not be breastfed has given rise to the importation and distribution of large amounts of formula which once available on the markets, has had the knock on effect of adversely influencing feeding practices in the community in general. More recently, with emergencies occurring in Eastern Europe and the Middle East where the prevalence of breastfeeding has been low to begin with, the problems associated with how to appropriately manage infants who do not have access to breastmilk have been increasingly highlighted.

There are several factors which may complicate decisions about optimal feeding practices in emergencies. These may create uncertainties for relief workers about the most appropriate management strategies for feeding infants under six months of age. The following factors have been described in recent emergency situations:

- mothers complain of having no milk
- mothers were not breastfeeding prior to the emergency
- breastfeeding practices changed during the crisis
- some breastfeeding infants appear to be malnourished
- wet nursing is not acceptable due to cultural taboos or HIV prevalence
- infants are orphaned
- bottle feeding is the norm

Before appropriate management can be undertaken it is necessary to correctly identify groups of infants for whom breastfeeding is problematic and the reasons behind the problem. It should then be possible to correctly identify the small group of infants out of this population for whom breastfeeding is not a realistic option. Correct categorisation of this latter group will help define the size of the problem and should lead to the identification of alternatives. This will also protect those for whom breastfeeding is a realistic option from misclassification on the basis of incorrect assumptions.
Triage is an act of sorting or categorising. This can be carried out from the moment the carer and child come in contact with the health care worker providing emergency relief. The triage/sorting framework proposed here was driven by ‘optimal feeding’ considerations for infants under six months. There is no attempt to identify or treat severe malnutrition among this age group. There are a number of reasons for this approach:

i) the method of feeding infants under 6 months of age is critically linked with child survival;

ii) there are uncertainties over:

- the best way to measure malnutrition/growth retardation in infants under 6 months
- whether the primary determinants of growth retardation are intra or extra-uterine factors
- how to measure and identify in the emergency context whether catch-up growth is occurring
- what is best practice for treatment of severely malnourished infants under 6 months

The main objectives of constructing a triage framework are:

i) to assist decision making about optimal feeding practices at field level;

ii) to encourage discussion of possible scenarios in the development and planning stage of a programme, thereby enabling agencies to be adequately prepared in terms of what kind of personnel, training and resources will be necessary.

It should be recognised that there is a hierarchy of feeding options available once infants are correctly classified into the appropriate feeding management group (see Prioritisation of Alternatives for Infant Feeding in Emergencies).

- For all situations of artificial feeding: (i) never use bottles – use cup; and (ii) monitor and report activities which break the Code and Resolutions

- Maternal nutrition is very important to all breastfed infants not only in terms of energy and proteins but also all the micronutrients. In situations where there is a dependence on a general ration, the under 6 month old infant's ration should be given to his/her lactating mother

### Scenario 1
**Mother accompanies the child: was breastfeeding prior to the emergency and has continued to breastfeed. There has not been an interruption in milk supply or a reduction in quantity.**

<table>
<thead>
<tr>
<th>Infant characteristics:</th>
<th>Normal well nourished healthy infant</th>
<th>Clinically undernourished/unhealthy infant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management:</td>
<td>1.1 Breastfeeding support</td>
<td>1.2 Breastfeeding support – as 1.1 and additionally</td>
</tr>
<tr>
<td></td>
<td>• advice &amp; encouragement</td>
<td>• clinical examination for presence of disease</td>
</tr>
<tr>
<td></td>
<td>• promote good maternal Nutrition</td>
<td>• treatment of disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• regular monitoring including growth monitoring until normal weight gain is identified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• if the infant is unwilling to suckle employ methods in 2.1</td>
</tr>
</tbody>
</table>

### Scenario 2
**Mother does not accompany the child, but a wet nurseFootnote 5 is available and willing. There has been no interruption in lactation.**

<table>
<thead>
<tr>
<th>Infant characteristics:</th>
<th>Normal well nourished healthy infant</th>
<th>Clinically undernourished/unhealthy infant</th>
</tr>
</thead>
</table>
**Infant characteristics:**

**Management:**

2.1 Breastfeeding support as 1.1 and additionally

- if there has been a period when the infant has not been suckling or where there was a change in feeding practice, patience and perseverance may be required to re-teach the infant how to suckle

- the infant's age and intake of complementary foods can also affect willingness to breastfeed, complementary foods if appropriate should be introduced after periods on the breast

2.1 Therefore manage as 1.2 and additionally

Because the infant has been separated from the mother, the period of separation and the feeding practices during separation must be assessed. It is possible that under-nutrition has occurred as a result of inappropriate feeding practices. Infection/disease may also be the cause of the infant's current status.

- ensure that the infant is suckling and receiving adequate amounts of breastmilk

- if the infant is unwilling to suckle it may be necessary for the wet nurse to express breastmilk which can be fed by cup to the infant at 150ml/kg/day in 8 to 10 feeds daily

- the infant can be encouraged to suckle by giving the expressed BM by dropper or feeding tube while the infant is at the breast.

**Scenario 3**

*Mother accompanies the infant, has breastfed pre-crisis but has experienced an interruption or a reduction in milk supply.*

<table>
<thead>
<tr>
<th>Infant characteristics:</th>
<th>Normal well nourished healthy infant</th>
<th>Clinically undernourished/unhealthy infant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management:</td>
<td>3.1 Relactation supportFootnote 6</td>
<td>3.2 Rehabilitate the infant and support relactation</td>
</tr>
<tr>
<td></td>
<td>While the mother's milk supply is becoming established and while the infant is learning to suckle it is of the utmost importance to ensure that the infant receives adequate nutrition. To give supplements in larger quantities or for a longer time than absolutely necessary is preferable than reducing them too much or too quickly.</td>
<td>The infant may be malnourished as a result of the interruption or reduction in lactation. While the mother’s milk supply is becoming established and while the infant is learning to suckle priority must be given to the infant’s adequate nutritional intake.</td>
</tr>
<tr>
<td></td>
<td>- examine and treat disease if necessary</td>
<td>- Examine for and treat disease if present</td>
</tr>
<tr>
<td></td>
<td>- ensure that the mother is receiving an adequate diet</td>
<td>- Start by giving the infant full nutritional requirements in addition to each breastfeeding session, continue as 3.1</td>
</tr>
<tr>
<td></td>
<td>- estimate infants daily requirements (150mls of full strength BMS/kg/day)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- if infant is willing to suckle, supplement pasteurised BM or BMS</td>
<td></td>
</tr>
</tbody>
</table>
with cup after suckling
• assess
• intake
• urination: frequency and intake
• activity level
• feeds vigorously
• weight gain – at least 125 grams per week
• reduction of supplements should be done cautiously, by no more than 50 mls in a 24 hour period. Continued weight gain with supplement reduction indicates that the milk supply is being re-established.
• continue like this until supplementation is no longer necessary.

| Scenario 4 | Infant is unaccompanied by mother, however there is a willing wet–nurse who has experienced an interruption or reduction in breast milk supply |
| Infant characteristics: | Normal well nourished healthy infant | Clinically undernourished/unhealthy infant |
| Management: 4.1 Relactation support | As above 3.1 ensuring wet–nurse receives an adequate diet. | 4.2 Rehabilitation and Relactation support |
| Management: 4.2 Rehabilitation and Relactation support | As above 3.2 ensuring wet–nurse receives an adequate diet. |

| Scenario 5 | Mother accompanying infant, she was not breastfeeding pre–crisis. However a wet nurse is available and this arrangement is acceptable. |
| Infant characteristics: | Normal well nourished healthy infant | Clinically undernourished / unhealthy infant |
| Management: 5.1 | Manage as 3.1 |
| Management: 5.2 | Manage as 3.2 |

| Scenario 6 | Mother accompanies infant, BF had not been established pre – crisis or there has been a gap in lactation. However, lactation is possible and acceptable |
| Infant characteristics: | Normal well nourished healthy infant | Clinically undernourished / unhealthy infant |
| Management: 6.1 | Management: lactation support as 3.1 |
| Management: 6.2 | Management: lactation support as 3.2 |

| Scenario 7 | Mother accompanies child was not breast feeding pre–crisis, lactation is unacceptable or not possible |
| Infant characteristics: | Normal well nourished healthy infant | Clinically undernourished / unhealthy infant |
### Infant characteristics:

### Management:

7.1 Support to limit risk associated with artificial feeding

- if breastmilk is available through milk banking this should be used otherwise a BMS (see hierarchy for appropriate BMS)

- ensure mother has access to a constant supply of BMS and necessary items e.g. fuel necessary for preparation

- ensure mother knows safe hygienic method of preparation

- ensure mother is aware of the dangers associated with artificial feeding

- monitor closely preparation method as well as infant weight gain and infants disease status

7.2 Examine for and treat disease if present and continue as 7.1

---

### Scenario 8

**Infant unaccompanied by mother, wet nursing not available or unacceptable**

<table>
<thead>
<tr>
<th>Infant characteristics:</th>
<th>Normal well nourished healthy infant</th>
<th>Clinically undernourished/unhealthy infant</th>
</tr>
</thead>
</table>

The most significant element of unaccompanied infant’s survival is care. A carer must be found who is interested in the child’s survival. The carer should be given the advise and support required to take care of the infant. Carers should not be motivated to care for children for financial or commodity gain.

<table>
<thead>
<tr>
<th>Management:</th>
<th>8.1</th>
<th>8.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manage as 7.1</td>
<td>Manage as 7.2</td>
<td></td>
</tr>
</tbody>
</table>

5. The practice of wet nursing may be unacceptable or inappropriate in situation of high HIV prevalence where testing, support and counselling are not available. (See WHO/UNICEF/UNAIDS, 1998 for more details.)

6. For more on relactation support see Annex VI.

Please note that: BF = Breastfeeding, BM = breastmilk, BMS = breastmilk substitute.

### Prioritisation of alternatives for infant feeding in emergencies

<table>
<thead>
<tr>
<th>1 Breastfeeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Wet–nursing*</td>
</tr>
<tr>
<td>3 Breastmilk from Milk Bank</td>
</tr>
</tbody>
</table>
Breastfeeding is the first and best feeding option for infants. No other food or liquid is required during the first 6 months of life − especially in emergency situations.

Other, less preferable, feeding options may be appropriate in certain circumstances. These are, in decreasing order of preference − wet nursing (where HIV risk is not high), and breast milk from a milk bank. If neither of these options is possible or acceptable, the next least dangerous option is provision of generically labelled infant formula with clear instructions on safe preparation. Agencies working in the area of infant feeding should have supplies of such formula for the small number of infants requiring it. Contact details of companies producing generically labelled infant formula can be obtained from Baby Milk Action (see annex VII).

Should interruptions in the generic supply occur it may be necessary to buy commercially labelled formula on the local market. As a very last resort and only when it is not possible to undertake any of the above options, home−made recipes may be considered (see annex IV). These lack key micro−nutrients that are necessary for adequate development and should therefore only be given for a few days until one of the other feeding options can be established.

* The practice of wet nursing may be unacceptable or inappropriate in situations of high HIV prevalence where testing, support and counselling are not available (see WHO/UNICEF/UNAIDS, 1998 for more details).

IFEG Strategy Paper, p7, point 3b

(3) To Minimise the dangers of artificial feeding to infants and their families, by:

b. facilitating the hygienic preparation of artificial feeds by parents/guardians of artificially−fed infants. In every case, this would include strongly discouraging the use of feeding bottles.

IFEG activity

Regarding this strategy point, Prof. Mike Golden contributed the following letter on cup feeding.

Cup Feeding

I have experience of both methods and am convinced that cup and saucer regimens are better. The possibility of inhalation pneumonia in the recovering severely malnourished child has concerned me for years. There is no information in the literature on lung function or aspiration pneumonia in the severely malnourished child at any stage of recovery. Nevertheless, examination shows that a very high proportion have stigmata of chronic chest disease, almost certainly due to repeated bouts of pneumonia, that could easily be precipitated by inhalation. There is a need for pulmonary physiological studies (lung−function tests) in children with severe malnutrition − if any one is interested in such a study please get in touch with me. The practice that we followed since 1956, in Jamaica, has been to use a cup and saucer, without a spoon, for the liquid feeds; spoons and bowls were used for solid food later in recovery. Choking and inhalation were more common in later recovery when solid food was given by spoon than when milk was given by cup only.

There is a definite technique to feeding a malnourished child properly. It is not taught to the people who either train the local staff or to the mothers. The critical thing is to have the child physically on the lap of the person feeding the child, held securely in a “cuddle” against the chest, facing forward in an upright posture, with the mother’s left arm encircling the child and holding the saucer under the chin. The right hand holds the cup for the child to drink. Any “dribbles” are collected in the saucer and returned to the cup. The most important thing is to teach the mothers how to hold their children during feeding and to have someone who is properly trained watching the children as they are fed.

With a spoon and cup there are several problems that I have repeatedly witnessed.

1. The feeding is very slow. This is a major difficulty because one of the main functions of the attendants is to watch the children during feeding. Such surveillance is critical to ensure that the child gets the food and to assess the child’s appetite. Rates of recovery improve with adequate surveillance as less is taken by the mother, none is shared with other siblings and more can be offered where the patient is hungry making feeding “to appetite” a reality.
2. There is a lot of spilt food. A lot of the milk “dribbles” down the front of the child and is lost. Investigation of poor weight gain, despite high calculated intakes, shows that up to a third of the meal can actually be spilt with improper feeding. Test weighings with the cup only method (weigh both the cup and the child before and after the feed), where a saucer below the chin catches the dribbles, gives a measured loss of just under 10%. With a spoon or with self-feeding the losses are much higher.

3. The child is often left to take the food him/herself. This is perhaps the most damaging feature of the spoon and cup. The child is not being cuddled and held during feeding and actively encouraged by the mother. Feeding is one of the most important times to show love and to psycho-socially stimulate the child – to talk to the child and have bodily contact.

4. Damage may occur during force feeding. If the child is reluctant to eat then the mother or aide frequently attempt to force the child’s mouth open by pinching the cheeks, holding the nose and/or forcing the spoon between the lips. A spoon causes much more trauma to a child’s mouth than a cup. I have seen children with stomatitis receive quite deep cuts in their mouths from spoons.

5. It is during force feeding that inhalation is most likely to occur. As force feeding is much easier with a spoon than a cup, it is my experience that inhalation pneumonia is more common following feeding with a spoon (both food and medicines) than with a cup only.

Going round Therapeutic Feeding Centres in West Africa, where cups and spoons were being used, I demonstrated to the local staff and mothers how to feed their children with a cup and saucer. They have all since reported back that they find this method to be better, problems that they had, have resolved and weight gains have improved.

I would like to hear from those who have a different practical experience from mine; such practical aspects of feeding the child are very important but have never been satisfactorily addressed by scientific investigation.

For further discussion on this subject contact Prof. Michael H.N. Golden, Department of Medicine and Therapeutics, University of Aberdeen, Forresterhill, AB25 2ZD, Scotland, (UK). E-mail: m.golden@abdn.ac.uk

(See also Annex VI)

Monitoring & Evaluation

Indicators for monitoring progress and evaluating impact of interventions to improve infant feeding in emergencies.

We can think of a programme as a specific set of activities that are all directed toward one or more defined objectives.

Decisions regarding programme objectives are often informed by pre-existing evidence that meeting these objectives will contribute to an overall goal.

For example, the objective of a programme to support and promote breastfeeding in a hospital maternity unit might be to increase the proportion of infants who are exclusively breastfed at discharge. The overall goal of the programme might be to reduce morbidity in infancy and to reduce expenditure by the hospital on the treatment of diarrhoea.

In order to assess progress in implementation of a programme and the extent to which the objectives of the programme are achieved, we need measurable indicators. Change in these indicators over time (usually before, during and after implementation of a programme) enables us to gauge the success of a programme.

We can distinguish three types of indicator: process indicators, outcome indicators and impact indicators. Process indicators measure the extent to which planned activities are taking place. Outcome indicators measure the extent to which programme objectives are being met. Impact indicators measure the extent to which the overall goals of a programme are achieved.
When there is robust evidence that particular goals can be achieved by meeting certain objectives (e.g. in the example of the hospital breastfeeding promotion programme, evidence that exclusive breastfeeding in early infancy reduces diarrhoeal morbidity), it is not usually considered necessary to measure impact (e.g. incidence of diarrhoea) as this can be inferred from changes in outcome indicators (rates of exclusive breastfeeding).

Clearly, outcome indicators are the key to determining whether the programme has done what it set out to do. It is also important to measure process indicators, because if outcome indicators fail to improve, process indicators can provide clues as to why (i.e. whether planned activities were not effective in meeting objectives, or whether they simply were not implemented as planned). In the example of the hospital breastfeeding promotion programme, process indicators could include the frequency and duration of contact between mothers and lactation counsellors. It is important to be explicit about both objectives and indicators when designing a programme, i.e., decisions on which indicators to use must be made before implementation begins.

For any emergency intervention with the goal of improving infant survival and health, appropriate impact indicators would include infant mortality and morbidity. In other words, these same impact indicators would be appropriate for any interventions involving breastfeeding or artificial feeding or both. As explained above, however, it is not always necessary to actually measure impact – and in some situations it is not practical anyway. The emphasis should instead be on measuring appropriate process and outcome indicators. For programmes involving infant feeding, these will differ according to the programme objectives. Examples are shown in the table below (NB: this is not an exhaustive list of all possible indicators, nor should it be seen as prescriptive or universally applicable; choice of indicators will vary from one programme to another).

<table>
<thead>
<tr>
<th>GOAL (with examples of impact indicators)</th>
</tr>
</thead>
<tbody>
<tr>
<td>improve infant health and survival</td>
</tr>
<tr>
<td>(diarrhoeal disease incidence; infant mortality rate)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Programme objectives (with examples of outcome indicators)</th>
</tr>
</thead>
<tbody>
<tr>
<td>support and promote breastfeeding (% of babies breastfed within 1 hour of delivery; % of babies exclusively breastfed at 1 month; % of babies exclusively breastfed at 3 months; average age at introduction of complementary foods; % of babies breastfed at 6 months; % of babies breastfed at 12 months)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activities (with examples of process indicators)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• train maternity care staff and other birth attendants (% of maternity staff/ birth attendants trained)</td>
</tr>
<tr>
<td>• deploy breastfeeding counsellors in health facilities and in community (no. of breastfeeding counsellors deployed; no. of mothers counselled)</td>
</tr>
<tr>
<td>• promote formation of mother–to–mother support networks (no. of mothers joining mother–to–mother networks)</td>
</tr>
<tr>
<td>• provide education on breastfeeding through health facilities and in community (% of mothers and % of general population receiving or recalling key messages)</td>
</tr>
<tr>
<td>• provide food supplements to breastfeeding mothers (as incentive to breastfeed) (% of breastfeeding mothers who regularly receive food)</td>
</tr>
</tbody>
</table>
Gaps in Knowledge: Areas for further study

IFEG identified a number of important gaps in current knowledge which it regarded as priorities for further study. It is hoped that operational agencies and research teams will form partnerships to address the following questions:

Field Level

- Does the provision of stress counselling (including trauma and sexual abuse) for lactating women improve breastfeeding outcomes in emergencies? If so, which subgroups of mothers/infants benefit most?

- Does the provision of family and community support for lactating women improve breastfeeding outcomes in emergencies? If so, which subgroups of mothers/infants benefit most?

- Does nutritional supplementation of lactating women improve breastfeeding outcomes in emergencies? If so, which subgroups of mothers/infants benefit most?

- In terms of: feasibility, cost effectiveness, morbidity and mortality, how does provision of breastfeeding support compare with the provision of breastmilk substitutes?

- How does emergency distribution of breastmilk substitutes affect breastfeeding practice in the community during and after the emergency? Can any adverse effects be reduced by improved targeting of breastmilk substitutes in emergencies?

- In terms of infant health and survival, what are the effects of using other breastmilk substitutes (including early introduction of solids) for infants under six months old, when both breastmilk and infant formula are unavailable?

- Under emergency conditions, does the risk of HIV transmission through breastfeeding outweigh the risk of infant death from artificial feeding among babies of mothers who are infected with HIV?

- Conduct further field testing and evaluation of recent guidelines on the treatment of severe malnutrition in infants less than 6 months old in emergency settings.

Agency Headquarters Level

- What is the frequency and volume of donations of breastmilk substitutes and feeding bottles from (i) general public and (ii) manufacturers of infant foods, to agencies for use in emergencies?

- Why are such donations made?

- Why are such donations requested and/or accepted and by whom?

Panels
Panel 1 – The International Code of Marketing of Breast–milk Substitutes

<table>
<thead>
<tr>
<th>The International Code of Marketing of Breast–milk Substitutes:</th>
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<tbody>
<tr>
<td>In 1979, WHO and UNICEF organised an international meeting on infant and young child nutrition. One of the recommendations made was that there should be an international code of marketing of infant formula and other products used as breastmilk substitutes. Member states of WHO and other groups/individuals who had attended the 1979 meeting, including representatives of the infant food industry, were then involved in a consultative process which culminated in the production of the International Code. This Code was endorsed by the World Health Assembly in 1981 in a Resolution which stressed that the Code is a “minimum requirement” to be enacted “in its entirety” by all countries.</td>
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</table>

The Code sets out the responsibilities of the infant food industry, health workers, national governments and concerned organisations in relation to the marketing of breastmilk substitutes, feeding bottles and teats as well as information regarding the use of these products. Since 1981, subsequent WHA Resolutions have been passed which aim to strengthen and clarify the Code. These Resolutions have the same status as the Code itself and should be read with it. The most important parts of the Code, which relate to infant feeding in emergencies, are:

**The Aim**

“The aim of this Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast–milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.”

**The Scope**

The Code applies to any product which is marketed or otherwise represented as a partial or total replacement for breastmilk, and to feeding bottles and teats. Only certain products are suitable as breastmilk substitutes, but many other unsuitable products (such as baby cereals, baby drinks and follow–on formulas) fall under the scope of the Code when they are marketed inappropriately.

**Advertising**

No advertising of above products to the public.

**Samples**

No free samples to mothers, their families or health care workers.

**Health care facilities**

No promotion of products i.e. no product displays, posters or distribution of promotional materials. No use of mothercraft nurses or similar company–paid personnel. No free or low–cost supplies.

**Health care workers**

No gifts or samples to health care workers. Product information must be factual and scientific.

**Supplies**

No free or low–cost supplies of breastmilk substitutes to maternity wards and hospitals. (The 1994 Resolution states that they should not be in any part of the health care system).

**Information**

Governments have the responsibility to ensure that “objective and consistent information is provided on infant and young child feeding”. Such information should never promote or idealise the use of breastmilk substitutes and should include specified points. It should also explain the benefits and superiority of breastfeeding and the costs and hazards associated with artificial feeding. Manufacturers should provide only scientific and factual information to health workers and should never seek contact with mothers.

**Labels**

Product labels must clearly state the superiority of breastfeeding, the need for the advice of a health worker and a warning about health hazards. No pictures of infants, or other pictures idealising the use of infant formula.
Products
Unsuitable products, such as sweetened condensed milk, should not be promoted for infants. All products should be of high quality (and should meet Codex Alimentarius standards, see annex V) and take account of the climatic and storage conditions of the country where they are used. Manufacturers and distributors should comply with the Code INDEPENDENTLY of government action to implement it. NGOs have a responsibility to report any violations to governments and to manufacturers.

The Resolutions most relevant to emergencies are:

The 1981 Resolution (WHA 34.22) stresses that the Code is a “minimum requirement” to be enacted “in its entirety” by all countries, that it should be translated into “national legislation” and that it should be monitored.

The 1986 Resolution (WHA 39.28) states that:

‘any food or drink given before complementary feeding is nutritionally required may interfere with the initiation or maintenance of breastfeeding and therefore should neither be promoted nor encouraged for use by infants during this period.’

‘The small amounts of breastmilk substitutes needed for a minority of infants should be made available through normal procurement channels and not through free or subsidised supplies.”

‘The practice being introduced in some countries of providing infants with specially formulated milks (so-called “follow-up milks”) is not necessary.’

The 1992 Resolution (WHA 45.34) reaffirms that ‘during the first four to six months of life, no food or liquid other than breastmilk, not even water, is required’ and endorses the WHO/UNICEF Baby Friendly Hospital Initiative.

The 1994 Resolution (WHA 47.50) states that:

‘mothers should be supported in their choice to breastfeed, obstacles should be removed and interference prevented in health services, the workplace or the community’;

‘complementary feeding should be introduced only from about 6 months’;

‘there should be no free or subsidised supplies of breastmilk substitutes or other products covered by the Code in any part of the health care system’;

In emergency relief operations, breastfeeding for infants should be protected, promoted and supported. Any donated supplies of breastmilk substitutes (or other products covered by the Code) may be given only under strict conditions: if infant has to be fed with breastmilk substitute; the supply is continued for as long as the infants concerned need it; and the supply is not used as a sales inducement.

The 1995 Resolution (WHA 49.15) states that:

‘financial support for professionals working in infant and young child health should not create conflicts of interest.’

‘monitoring of the Code and subsequent relevant resolutions should be carried out in a transparent independent manner, free from commercial influence.’

Panel 2 – UNICEF/WHO Baby Friendly Hospital Initiative: Ten Steps to Successful Breastfeeding

UNICEF/WHO Baby Friendly Hospital Initiative: Ten Steps to Successful Breastfeeding

To become a Baby Friendly Hospital, every facility providing maternity services and care for new-born infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.

3. Inform all pregnant women about the benefits and management of breastfeeding.

4. Help mothers initiate breastfeeding within half an hour of birth.

5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.

6. Give new-born infants no food or drink other than breastmilk, unless medically indicated.

7. Practice rooming-in – allow mothers and infants to remain together 24 hours a day.

8. Encourage breastfeeding on demand.

9. Give no artificial teats or pacifiers (dummies or soothers) to breastfeeding infants.

10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Panel 3 – Training on Infant Feeding in Emergencies

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<thead>
<tr>
<th>Training on Infant Feeding in Emergencies</th>
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<tr>
<td>Currently there are no specific courses on infant feeding in emergencies. The Centre for International Child Health in London is investigating the feasibility of offering specialised courses or training modules and would be interested to hear from individuals and organisations who would like to participate.</td>
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</table>

There are several recognised courses on infant feeding in non-emergency situations as outlined below. These differ principally in the amount of time and skills training in counselling, the technical content and the degree of orientation towards a hospital or community setting.

Any of these courses would provide a useful grounding for health professionals working in emergencies. The WHO–40 hour course is highly recommended for personnel who are directly working with mothers. It would be an ideal course to set up in an ongoing emergency situation in order to train up local counsellors.

1. **Breastfeeding management and promotion in a Baby Friendly Hospital**

Organised through WHO/UNICEF Baby Friendly Initiative programme.

An 18-hour course aimed at health staff implementing the BFI. Covers clinical aspects and counselling skills, but not in detail. Available in UK as a modular course. Usually conducted in implementing health trusts, but open course periodically available. Contact UK BFI office for details. Footnote 7

7. UNICEF–UK BFI, P.O. Box 29050, London WC2H9TA, tel.: +44 171 8365901, Fax: +44 171 3795795, e-mail: bfi@unicef.org.uk

2. **Breastfeeding counselling: a training course**

Organised through WHO, usually in liaison with local health authorities.

A 40 hour (2 week) in–depth counselling course designed to train trainers (attend for 2 weeks) as well as train counsellors (attend for second week only). Covers clinical aspects.

3. **Breastfeeding: Practice and Policy course**

Held in collaboration with WHO and UNICEF at the Centre for International Child Health, Institute of Child Health, London. A 4 week advanced level international course for senior health professionals in a position to influence practice and policy. Intensive technical and skills based course which covers clinical skills and counselling. Takes place annually in July.
4. IBFAN/UNICEF: Training guide in lactation management

(Also known as the Master Trainers Course). An 80–hour course designed to train trainers who can become trainers of Baby Friendly Hospital assessors.

Panel 4 – Stop–gap recipes only to be used as a last resort in extreme situations

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<thead>
<tr>
<th>Stop–gap recipes only to be used as a last resort in extreme situations</th>
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<tr>
<td>Types of Milk</td>
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<th>Protein (g)</th>
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ALTERNATIVELY: The F100 diet is a therapeutic milk designed to support rapid growth in severely malnourished children and is absorbed by the damaged intestine of older children; as such in an emergency where nothing else is available, could be used (diluted into 2.8, instead of 2 litres) for infants for a short time, although it has not been tested in this role. It is very low in iron so that any infant given this diet is likely to develop iron deficiency. Also for the proper use of this commodity it is important that it is not perceived as a breast milk substitute.

Panel 5 – Breastmilk Substitutes – Specification Standards

<table>
<thead>
<tr>
<th>Breastmilk Substitutes – Specification Standards</th>
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<tbody>
<tr>
<td>The Codex Standard for Infant Formula was adopted by the Codex Alimentarius Commission</td>
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<tr>
<td>For Specifications see:</td>
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<tr>
<td>Codex Alimentarius Volume Four</td>
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<tr>
<td>Foods for special dietary uses</td>
</tr>
<tr>
<td>(including foods for infants and children)</td>
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<tr>
<td>FAO , Rome 1994</td>
</tr>
<tr>
<td>The EU Commission has also issued directives on Infant formula Specifications</td>
</tr>
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<td>For Specifications see:</td>
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<tr>
<td>Commission Directive 96/4/EC</td>
</tr>
<tr>
<td>Official Journal of the European Communities</td>
</tr>
<tr>
<td>No L 49/12, Feb.1996</td>
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Panel 6 – Re–Lactation, Hand Expression and Cup Feeding – A Brief Guide for Aid Workers

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<tr>
<th>RE–LACTATION, HAND EXPRESSION AND CUP FEEDING – A BRIEF GUIDE FOR AID WORKERS</th>
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<tbody>
<tr>
<td>Introduction</td>
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<tr>
<td>In emergency situations infants are an especially vulnerable group. Breastfeeding is the safest and simplest way of ensuring that they reliably get the nutrients they need for adequate growth and for the development of their brains and central nervous systems. Breastmilk also provides priceless protection against illnesses that are rampant in natural</td>
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and man–made disasters. Even under these very stressful circumstances, most mothers need only a little information and support to breastfeed their infants. Some mothers will need a little more help to establish or maintain a good milk supply. This annex outlines ways in which aid workers can be helpful to these mothers

1. Establishing a Breastmilk Supply: Re−lactation (and induced lactation)

For many reasons a woman who is not lactating or only barely lactating may find herself in a situation with an infant who needs to be breastfed. A woman who has been pregnant at any time in the past can usually re−lactate. Even post−menopausal women have relactated successfully. Many women who relactate produce enough milk to breastfeed an infant exclusively. A woman who has never been pregnant can establish lactation (this is called induced lactation); although this is more difficult and the amount of milk produced may be less than is needed for exclusive breastfeeding. Establishing a milk supply depends primarily on the infant’s suckling. Younger infants tend to be more willing to suckle than older infants, but there are reports of children over a year old who have been breastfed after relactation.

1a) How to establish a breastmilk supply.

What can YOU do to help?

• A woman who wants to relactate must be well motivated and have good support if she is going to manage it. Give her confidence that she can produce milk. Reassure her that you will help her.

• Let the mother know that it may take several days – perhaps even two weeks or more – for the milk to start coming in and possibly several more weeks (2–6 weeks) before she is able to breastfeed exclusively. A woman inducing lactation for an orphaned infant will probably need even longer.

• Explain to the mother, her family and her health care workers that it might help her, while she is building up her milk supply, if she can get someone to help her with her daily tasks. Look into getting her priority in food and water queues with other lactating mothers.

• Make sure that the mother has extra rations, the same as other lactating women.

• Assist the mother with breastfeeding advice, hand expression (see section 2a) and with any other needs she may have.

What should the MOTHER do?

• Skin−to−skin contact stimulates the release of the hormone prolactin, which is necessary for milk production. Encourage mothers to keep their infants close to them and have as much skin−to−skin contact as possible.

• Correct attachment and positioning of the infant to the mother’s breast is important for stimulating a good milk supply, and protecting against any potential problems such as sore nipples. Make sure the mother understands how to position and attach her infant to her breast to ensure effective suckling and removal of her breastmilk. (Note: See box for a brief guide on positioning and attachment).

• The more often the breast is stimulated, the more milk will be produced. The mother should put their infant to each breast at least 10−14 times in a 24−hour period (every 1–2 hours in the day and whenever possible at night) for as long as the infant is willing to suckle. If a mother is not producing much (or any) milk, an infant may be reluctant to suckle long enough to provide good stimulation. The mother can encourage her infant to stay at the breast longer by dripping milk into the corner of his/her mouth or by using a breastfeeding supplementer (see section 1b). Remember that depending on how long it is since the mother stopped lactating, it can take a couple of weeks for the milk to arrive and even longer before a mother is able to breastfeed exclusively.
• The levels of prolactin – the milk producing hormone – are highest at night. Therefore, if possible, the infant should sleep with his/her mother and breastfeed whenever they wake at night. Frequently an infant is more willing to suckle when he/she is sleepy (or sleeping) than when he/she is wide-awake. Note: never force the infant onto the breast.

• The mother must learn to “baby-watch” so she can pick up her infant’s signals of interest, for example, licking his/her lips, opening and closing his/her hands and mouth, moving his/her head around and so on (this is often called “mouthing” or “rooting”). If the mother can squeeze a small amount of her milk onto her infant’s lips or tongue it may awaken his/her interest.

• The infant should not be given a dummy or pacifier. They may reduce the infant’s interest in suckling at the breast and can be difficult to keep clean, especially in emergency situations.

• If the infant is not willing to suckle as frequently as needed, the mother can stimulate her milk production by hand-expression between feeds (see section 2a) or whenever possible, preferably every 1–2 hours. Keep in mind, however, that the infant’s suckling is the best way to stimulate milk production. In order to stimulate her milk production the mother should also touch her nipples frequently until they become erect.

A brief guide on positioning and attachment during breastfeeding

• Breastfeeding should NOT hurt; if it does hurt it is wrong, take the infant off the breast and start again.

• Correct positioning. The infant’s head and body should be in line and turned towards the mother. The infant’s nose or upper lip needs to be opposite the nipple.

• When the infant attaches to the breast the mother should wait until the infant has a wide mouth – about 90 degrees. If he/she doesn’t open spontaneously, the mother can stroke her infants lower lip with her breast or finger until he/she does.

• As soon as the infant has his/her mouth open she should quickly take the infant to the breast, with the infant’s chin leading and aiming his/her lower lip below the nipple well back on the areola (the dark area surrounding the nipple) and the nipple towards the infant’s nose.

• There should be more areola visible above the infant’s mouth than under the chin. [The infant should be breastfeeding not nipple feeding, the nipple is only part of what should be taken into the infant’s mouth; the rest is breast tissue taken in by the tongue from below the nipple. Nipple sucking is very painful and is not effective in stimulating milk production.]

• If attached correctly the infant’s chin should be touching the breast and the infant should have a wide mouth. The infant’s lower lip should also be flanged out – however this may be hard to see so don’t check for this if it means that you will unintentionally break the infants attachment.

• If the infant is well attached he/she will be swallowing and will have slow deep sucks followed by pauses. [The infant will suck quickly at first before getting into a slow deep sucking rhythm. The infant will pause occasionally (he/she is waiting for more milk to come down) this does NOT mean that the infant has finished.]

Note: The infant should be left to come off the breast when he/she wants. A mother will know when her infant has finished the first breast when he/she comes off the breast or falls asleep. She can then burp him/her and offer the second breast, which he/she may or may not take.

1b) How should an infant be fed before enough breastmilk is produced?

• While lactation is being established the infant will need to be artificially fed. Give the full amount of artificial milk required (150mls per kg per day) until the milk starts coming.

• Feed the breastmilk substitute (BMS) by cup (see section 3) or with a breastfeeding supplementer (see below).
• As soon as her breastmilk appears the mother can start to reduce the amount of BMS she is giving her infant. Start by reducing the BMS given by 30–50mls a day – either in one feed or spread out over each of them. If the infant continues to gain weight and has 6–8 very wet nappies a day the BMS can be reduced by another 30–50mls every two to three days. However, reducing the BMS too quickly can compromise the infant’s growth and cause the mother unnecessary additional anxiety.

• In order to determine that the infant is getting enough milk it is important to check the infant’s weight gain (over 125g a week), urine output (it should be abundant, pale yellow or clear in colour) and fontanel (it should not be sunken). If the infant appears not to be getting enough milk then give the same quantity of BMS for a few days and if necessary increase the amount of BMS for a day or so. Moreover, it may sometimes be necessary – during a growth spurt, for instance – to increase the BMS a little and then go back to reducing it slowly again.

• Supplementing while breastfeeding. A helpful method of re-establishing or inducing lactation is to feed the BMS to the infant while he/she is suckling. In this way the infant’s efforts are rewarded, and the infant’s suckling stimulates the production of milk. This method is useful if an infant is not interested or is too weak to suckle from a breast that does not produce milk yet. The supplement used can be artificial milk, pasteurised donated breastmilk or preferably the mother’s own expressed milk (if she is producing any). The supplement can be put into the side of the infant’s mouth using a syringe or dropper while the infant is suckling, it can be dripped onto the mother’s breast so that it goes into the infant’s mouth while the infant suckles, or, if cleanliness and sterilisation can be assured, then a “breastfeeding supplementer” can be used. This consists of a cup or bottle of supplement, with a fine tube which leads from the bottom of the container, along the length of the mother’s nipple (at the top or side) and into the infant’s mouth.

What YOU can do to help a mother use a breastfeeding supplementer.

• Show the mother how to use the supplementer and how to keep it absolutely clean. The tube needs to be sterilised after every feed and changed every few days.

• Show the mother how to regulate the flow of milk from the supplementer so that the infant does not feed too fast and so that the breast is stimulated; the infant should suckle for about 30 minutes at each feed if possible. If the flow is too fast it can be regulated by closing the tube a bit with a paper clip, a knot, or by lifting or lowering the container.

• Explain to the mother and her family or friends that she may need some help during this procedure, for example, by holding the cup.

• Remind the mother to let her infant suckle at any time he/she is willing – not only when she is using the supplementer.

2. Expression of breastmilk

All mothers should learn how to express their milk. This is useful if the mother is separated from her infant; if the infant is too weak to suckle; if the breasts are severely engorged; or to stimulate milk production, for example, when relactating. Expression can be done by hand or with a pump (hand or electrical); however, in emergencies it is very unlikely that pumps or electricity will be available so this section will concentrate on hand expression.

What should the MOTHER do to express her breastmilk?

2a) Hand expression

What YOU can do to help:

• Ensure that the mother has some privacy.
• Help her to relax.

• Provide practical support by providing her with the equipment she needs e.g. a container.

She should:

a. Wash her hands thoroughly.

b. Prepare a very clean cup or container with a wide neck to collect the milk in.

c. Relax, get comfortable and think of her infant, if her infant is not there it may be useful if she has something of her infant with her, e.g. a photograph or a piece of her infant’s clothing to smell.

d. Stimulate her breast to release milk (this is called the let-down reflex) by gently massaging and stroking her breasts from the outside in towards the nipple and touching her nipples until they are erect.

e. Lean slightly forward so that the milk can be collected in the container.

(Note: the following is just one method, she may find a way that suits her better.)

f. Hold her breast by placing her four fingers underneath and her thumb on top. Her index finger and thumb should be about 4cm (an inch and a half) away from the base of the nipple; this may or may not correspond to the outer edge or her areola depending on its size. Her fingers should be over her lactiferous sinuses, which are the areas in the breast where the milk collects; some women can feel these as small round thickenings under their fingers.

g. Press her fingers in slightly towards the chest wall.

h. Compress the breast tissue (lactiferous sinuses) between her fingers, and then release. Press and release, simulating as much as possible the rhythm of her infant’s suckling. This should not hurt; if it does hurt she is doing it wrong and needs to improve her technique. She should not hurt herself by squeezing, rubbing, pushing or pulling too vigorously. Some mothers find that using a rolling motion with their thumb and fingers compresses and empties the milk reservoirs without hurting the sensitive breast tissue.

i. Be patient, even if no milk comes at the beginning.

j. Move her hands around her breast so that she expresses from all areas of her breast.

k. Express one breast for at least 3–5 minutes until the flow slows; then express the other side, then repeat both sides. She can use either hand for either breast or both hands.

Note: Expressing breastmilk adequately can take 20–30 minutes or even longer; especially in the first few days when only a little milk is produced. The mother should be encouraged to express for at least this long several times a day.

2b) Storage and use of stored breastmilk

Expressed breastmilk must be stored in a sterilised, closed container in the coolest place available. Current guidelines are that it can be stored for up to 6–8 hours at room temperature (26°C/78°F or lower) – although it is best to refrigerate the milk as soon as possible if it is not being used – and for 24–48 hours in a refrigerator (4°C). After 48 hours all milk should be frozen at −18°C. It can be stored in the freezer for 3 months, as long as the temperature is maintained. If there is a power failure then the milk being stored in the fridge or freezer should be consumed within 8 hours, after this time it should be thrown away.

Note: (i) It is easier to use if milk is frozen in small, portion-size amounts. Never re-freeze it, but keep it in the refrigerator for use within 48 hours. (ii) Let the breastmilk thaw in the room, it should be used when it is at room temperature. It should not be heated, if necessary it can be thawed by placing the container in some warm water.
3. Feeding by cup

Most babies do not need to feed from anything other than the breast until they are about 6 months old. However, if the infant does need supplementation then this should be given by the supplementation techniques described in section 1b or by cup; bottles and teats should not be used as they may cause sucking confusion. Moreover, in emergency situations it is difficult – or impossible – to ensure the cleanliness and sterility of this equipment.

**How do you cup feed an infant?**

- Place the wide-awake infant in an upright position sitting on your lap.
- Support the infant’s shoulders and neck with your hand, so that you have some control over the infant’s head. It may also be helpful to tuck the infant’s arms away by wrapping him/her up; this can also help to support him/her.
- Half fill a small cup. It is best if it is transparent so you can see the milk and with a thin rim (the rim must not be sharp).
- Place the cup at the infant’s mouth, resting the cup gently on the infant’s lower lip and so that the edges of the cup are at the corners of the infant’s mouth (where the top and bottom lips meet).
- Tip the cup so that the milk reaches its rim and the infant’s lower lip. Aim to keep the cup in this position.
- A pre-term or sick infant may lap the milk at first with the tongue, while a full-term infant will sip the milk. DO NOT pour the milk into the infant’s mouth.
- Be patient. Take the lead from the infant; let him/her decide when he/she has had enough.
- In order not to waste milk some people like to use a saucer to catch the spilt milk. With practise the mother can do this or somebody else can hold it (see page 24).
- Measure the infant’s intake over 24 hours; the amount the infant has at each feed will vary.

### Panel 7 – Meeting Participants

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<th>Meeting Participants</th>
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<tr>
<td><strong>Core Participants:</strong></td>
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<td>Kathy Carter</td>
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<td>Communications and Information Manager</td>
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<tr>
<td>Appropriate Health Resources &amp; Technology</td>
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<td>Farringdon Point</td>
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<td>29–35 Farringdon Road</td>
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<td>London, EC1M 3JB</td>
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Occasional Participants:  

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Beata Anczykowka</td>
<td>Micnovic</td>
</tr>
<tr>
<td>Tricia Anderson</td>
<td>Tear Fund</td>
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<td>BF Counsellor</td>
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<tr>
<td>Mary Corbett</td>
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</tr>
<tr>
<td>Coral Jepson</td>
<td>AHRTAG</td>
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</table>
Panel 8 − Further Reading

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Sandra Lang</td>
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</tr>
<tr>
<td>Trudie Price</td>
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</tr>
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<td>Baby Milk Action Ireland</td>
</tr>
<tr>
<td>Andy Seal</td>
<td>ICH</td>
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<tr>
<td>Major Dawn Sewell</td>
<td>Salvation Army</td>
</tr>
<tr>
<td>Liz Smith</td>
<td>VSO</td>
</tr>
<tr>
<td>Anna Taylor</td>
<td>UNICEF/GBM</td>
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<td>Andrew Tomkins</td>
<td>ICH</td>
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<tr>
<td>Sarah Uppard</td>
<td>SCF</td>
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<tr>
<td>Jill Volpe</td>
<td>British Red Cross</td>
</tr>
<tr>
<td>David Westwood</td>
<td>World Vision</td>
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<tr>
<td>Alan Waites</td>
<td>International World Vision</td>
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<tr>
<td>Sue Woolley</td>
<td>Baby Milk Action (IBFAN)</td>
</tr>
<tr>
<td>Helen Young</td>
<td>OXFAM</td>
</tr>
</tbody>
</table>

**Further Reading**

The following documents contain further relevant information:

**HIV and Infant Feeding Documents:** (1) Guidelines for decision makers, (2) Guide for healthcare managers and supervisors, (3) A review of HIV transmission through breastfeeding.

*Published by:* UNICEF, UNAIDS, WHO.
*Date:* 1998
*Available from:* WHO marketing and dissemination, CH–1211 Geneva 27, Switzerland. publications@who.ch


*Author:* Sokol E.
*Date:* 1997
*Available from:* International Code Documentation Centre and IBFAN.

**Breastfeeding, How to Support Success**

*Published by:* WHO
*Author:* Vinther T. and Helsing E.
*Date:* 1997
*Available from:* Dr. Aileen Robertson, 8 Scherfigsvej, DK–2100 Copenhagen, Denmark.

**Guiding Principles for Feeding Infants and Young Children during Emergencies**

*Published by:* WHO
*Date:* draft
*Available from:* Mrs Randa Saadeh, WHO, 20 Ave Appia, CH 1211, Geneva 27, Switzerland

**How to Breastfeed during an Emergency – A Guide for Mothers**

*Published by:* WHO
*Authors:* Robertson A, Helsing E, & Vinther TD
*Date:* March 1997
*Available from:* Dr Aileen Robertson, Regional Office for Europe, Programme for Nutrition Policy, WHO, 8
Scherfigsvej, DK–2100 Copenhagen, Denmark.

**Breastfeeding and Food Security**
Publication: Infancy Newsletter  
Date: 1996  
Available from: INFACHT Canada, 6 Trinity Square, Toronto MSG IBI, Canada

**Breastfeeding and HIV: Making an Informed Choice**  
Published by: CBI, La Leche League International  
Date: 1996  
Available from: Centre for Breastfeeding Information, La Leche League International, Schuamberg, IL 60168 – 4079, USA

**Breastfeeding During an Emergency – Teaching Materials**  
Publication: Project During Breastfeeding Module of the Diploma/MA in Health Promotion, UCG  
Author: Crangle E  
Date: 1996  
Available from: Genevieve Becker, Dept of Health Promotion, UCG, Ireland

**Concern Worldwide, Nutrition Emergency Module**  
Date: 1996  
Available from: Annalies Borrell, Concern Worldwide, 1 Upper Camden St, Dublin 2, Ireland

**Crucial Aspects of Infant Feeding in Emergency and Relief situations** (a 70 Page book containing reprints of many relevant others).  
Publication: IBFAN Regional Coordinaton Office for Europe, c/o Geneva Infant Feeding Association  
Date: 1996  
Available from: IBFAN Europe, c/o GIFA, B.P. 157, 1211 Geneva 19, Switzerland. Also available from Baby Milk Action: 23 St. Andrews Street Cambridge CB2 3AX E-mail babymilkacti@gn.acp.org

**Discussion on Infant Feeding in Emergency and Relief Situations**  
Published by: Wemos  
Date: 1996  
Available from: Wemos, P.O. Box 1693, NL – 1000 BR Amsterdan, The Netherlands

**Feeding in Emergencies for Infants Under Six Months; Practical Guidelines**  
Published by: OXFAM  
Authors: Carter K / OXFAM Public Health Team  
Date: 1996  
Available from: OXFAM, 274 Banbury Road, Oxford OX2 7DZ, England

**Infant and Young Child Feeding in Emergencies (Final Draft)**  
Authors: Wellstart International, Expanded Promotion of Breastfeeding Program  
Date: 1996  
Available from: Jean Baker, Project Director  
The LINKAGES Project, Academy for Educational Development (AED), 1255 23rd Street, N.W. Washington, D.C. 20037, U.S.A.

**Not Enough Milk: Helping Mothers Who Complain of ‘Not Enough Breastmilk’**  
Publication: Update No 21  
Date: 1996  
Available from: The Director, Division of Diarrhoeal and Acute Respiratory Disease Control, WHO, 1211 Geneva 27, Switzerland

**Rapid Assessment of Infant Feeding Practices in Two Rwandan Refugee Camps**  
Published by: Wellstart International  
Authors: Lung’aho M.S, Clause B & Butera F  
Date: 1996  
Available from: Wellstart International, Expanded Promotion of Breastfeeding Program, 3333 K Street, NW, Suite 101, Washington DC 20007, USA
Ten Steps to Successful Breastfeeding: A Summary of the Rationale and Scientific Evidence
Publication: Birth No 23:3
Authors: Saadeh R & Akre’ J
Date: 1996
Available from: Mrs Randa Saadeh, WHO, 20 Ave Appia, CH 1211, Geneva 27, Switzerland

Published by: WHO
Date: 1996
Available from: WHO Publications, Distribution and Sales, 1211 Geneva 27, Switzerland

Nutrition Guidelines
Published by: MSF
Edited by: Airbelot, A.
Date: 1995
Available from: MSF Paris

Birthweight and Breastfeeding of Babies During the War in One Municipal Area of Sarajevo
Author: Moro D
Date: 1995

Breastfeeding in Refugee Situations
Publication: Breastfeeding Briefs No 21
Date: 1995
Available from: GIFA, B.P. 157, 1211 Geneva 19, Switzerland

Infant Feeding in a Refugee Camp
Publication: Midwives
Author: Toothill B
Date: May 1995
Available from: Midwives, 120 High Road, East Finchley, London N2 8AG, England

Nutrition and Care of Young Children During Emergencies
Publication: Food and Nutrition Bulletin Vol 16 No 4
Author: Longhurst R
Date: 1995

Nutrition and Immunization Survey of Bosnian Women and Children during 1993
Publication: International Journal of Epidemiology, Volume 24 No 6
Authors: Robertson A, Fronczak N, Jaganjac N, Hailey P, Copeland P & Duprat M
Date: 1995
Available from: Dr Aileen Robertson, WHO, 8 Scherfigsvej, DK – 2100 Copenhagen, Denmark.

Statement on the Use of Milk Products During Emergencies
Published by: CIDA
Date: 1995
Available from: CIDA, Multilateral Programmes Branch, 200 Promenade du Portage, Hull, Quebec, Canada

Body Mass Index and Lactation Performance
Publication: European Journal of Clinical Nutrition: No 48;3
Authors: Prentice AM, Goldberg GR, & Prentice A
Date: 1994

Breastfeeding During the HIV Epidemic. The Dilemma: Preventing Vertical Transmission or Preventing Death
Publication: Journal of Tropical Paediatrics Volume 40
Author: Cutting W
Date: 1994
Lactation – How important is it?
Publication: Journal Royal Society of Health 114 (1): 19–28
Authors: MacIntyre UE & Walker AR
Date: Feb 1994

Socio–Cultural Considerations for Infant Feeding In Emergencies: A Discussion Paper
Author: Almedon A
Date: 1994
Available from: Dr Astier Almedon, Health Promotion Sciences Unit, Dept of Public Health & Policy, London School of Hygiene & Tropical Medicine, Keppel St, London WC1E 7HT, England.

Breastfeeding counselling: A training course
Publication: WHO (and UNICEF)
Date: 1993
Available from: WHO, Ch−1211, Geneva 27, Switzerland

Infant Feeding in Emergencies
Publication: Disasters. Volume 7 No 2
Author: Kelly M
Date: 1993

Maternal Malnutrition and Breastfeeding; is There Really a Choice for Policy Makers?
Publication: Journal of Tropical Paediatrics. 37 Suppl
Author: Huffman S
Date: Oct 1991

Child Weaning Practices in Times of Crisis
Publication: RPN
Author: Almedon A
Date: 1990
Available from: Dr Astier Almedon, Health Promotion Sciences Unit, Dept of Public Health & Policy, London School of Hygiene & Tropical Medicine, Keppel Street, London, WC1E 7HT, England

Constraints on Weaning: Evidence from Ethiopia and Sudan
Publication: Journal of Biosocial Science; Volume 22
Authors: Almedon A & de Waal A
Date: 1990

Innocenti Declaration; On the Protection, Promotion, and Support of Breastfeeding
Published by: WHO
Date: 1989
Available from: WHO, 20 Ave Appia, CH 1211 Geneva 27, Switzerland

Assisting in Emergencies. A resource handbook for UNICEF field staff
Published by: UNICEF
Author: Ockwell, R.
Date: 1986

Milk for Hungry Children – Some Questions
Publication: IBFAN−Africa Newsletter
Author: Armstrong H
Date: Feb 1985
Available from: IBFAN Africa, P.O. Box 781, Mbabane, Swaziland

The Effect of Water Abstention on Milk Synthesis in Lactating Women
Publication: Clinical Science; Volume 66
Author: Prentice A
Date: 1984

Maternal and Child Programmes in Refugee Camps: Key Issues
Publication: Advances in International Maternal and Child Health Volume 3
Authors: Jelliffe DJB & Jelliffe EFP
Chapter 2 – Annex 5: Malnutrition, Nutrient Requirements and Nutrient Sources

Protein–Energy Malnutrition (PEM)

Protein–energy malnutrition results from low intake or poor absorption of food, usually due to inadequate availability or infection. In most cases, PEM affects children between six months and five years of age, and is a particular threat at the time of weaning. However, recently it has been demonstrated that the process of becoming malnourished already starts in infants younger than 6 months, stressing the importance of exclusive breastfeeding until the child is about 6 months of age. PEM takes three forms: nutritional marasmus, kwashiorkor, and marasmic kwashiorkor.

Nutritional marasmus

Nutritional marasmus is the most frequent form of PEM in situations of long–term food shortage, resulting from prolonged inadequate food intake. Weight is lost, fat and muscle waste away. The child becomes very thin, may have sunken eyes, an ‘old man’ face and loose folds of skin especially on the buttocks. The child may, nevertheless, appear relatively active and alert.

Kwashiorkor

Kwashiorkor is seen most commonly among infants recently taken off the mother’s breast and in areas where tubers and roots (e.g. cassava) are the main staple foods, putting the child at risk for protein deficiency.

The main sign is oedema, swelling of the feet and lower legs that may extend in advanced cases to the arms and face. Where there is gross oedema, the child may look ‘fat’ and be regarded by his parents as being well–fed. To check for oedema, press with thumb or finger for three seconds on the top of the foot near the ankle, if a definite pit remains after the finger is removed, oedema is present.

Other signs, which do not always occur, include:

- ✓ hair changes – color becomes lighter, curly hair becomes straight, and hair comes out easily with a gentle pull; and
- ✓ skin changes – skin becomes lighter in places, skin may peel off, especially on the legs, and ulceration may occur.

Children with kwashiorkor are usually apathetic, miserable and withdrawn, and often refuse to eat. Profound anaemia is a common complication of kwashiorkor.
Marasmic kwashiorkor

Marasmic kwashiorkor is a common combination of the above two conditions. The child appears thin and wasted but with swollen lower limbs.

Classification of Protein–Energy Malnutrition

Classification of protein–energy malnutrition according to weight, height and oedema is summarized in Panel 1. Also shown are criteria for classifying severe malnutrition as ‘oedematous’, ‘wasted’ or ‘stunted’.

Vitamin and mineral deficiencies

Vitamin and mineral deficiencies affect persons of all ages and are a particular danger in situations where supplies of fresh foods and produce are disrupted and the nutritional quality of the diet is reduced. It should be realized that young children from developing countries living under ‘normal’ circumstances often already suffer from micronutrient deficiencies without showing early recognizable symptoms. Even when a child suffers from these subclinical deficiencies significant negative impacts exist on growth, health, mental and physical performances. Clinical symptoms of malnutrition caused by vitamin or mineral deficiency vary enormously, depending on the specific nutrient deficiency. (Possible forms of malnutrition caused by vitamin or mineral deficiency are summarized in Panel 2.)

Acute deficiencies in individuals must be treated by providing concentrated doses of the particular vitamin/mineral. Panel 3 summarizes action in respect of vitamin A deficiency.

All possible efforts should be made to provide a diet that can cover the needs for micronutrients. It is especially important to try to provide fortified foods such as iodized salts, oils/fats fortified with vitamin A, iron fortified flour.

If adequate diets cannot be provided sufficiently quickly and fortified foods are not available, large-scale administration of the specific vitamin and/or mineral is required. Multi–vitamin and mineral supplements are available and may be very useful to rapidly improve vitamin and mineral status of at-risk population groups such as pregnant women and young children. Most developing countries provide iron tablets to pregnant women (one tablet containing 60mg iron and 400g folate a day during the second half of pregnancy) and vitamin A capsules to 6–60 month old children (one large dose capsule every 6 months).

Efforts should be made to guarantee that pregnant women do at least get iron tablets and that vitamin A capsules are available for 6–60 month old children. In case no foods rich in vitamin A and/or fortified foods are available, all 6–60 month old children should receive one large dose vitamin A capsule every 6 months.

Nutrient Requirements

What constitutes adequate nutrition is a matter for which there is not complete consensus among UN agencies and NGOs active in emergencies. Panel 4a presents the base planning figures of various agencies concerning average per capita energy requirements, and Panel 4b presents agency recommendations concerning how this base planning should be adjusted in accordance with demographic distribution, health and nutrition status, activity levels and climate.

Agency recommendations on fat and protein contents also vary to some degree. ICRC recommends that fat provides 19 per cent of total energy, WHO recommends 15–20 per cent, and WFP and most other agencies recommend that fat provides a minimum of 10 per cent of total energy. Agency recommendations for protein range from 8 to 12.5 per cent of total energy.

Micronutrient requirements: In emergencies, priority in meeting nutrient requirements should be, first, to ensure sufficient dietary energy (kcal) for survival and maintenance; second, to ensure necessary general protein content; and third, to ensure appropriate intakes of particular amino acids, vitamins and minerals.
The basic types of nutrients are summarized in Panel 5.

**Food Commodities and Diets**

Panel 6 indicates the energy and protein content of some common food items. The referenced publications provide further details and suggestions for various diets using items likely to be available and acceptable in various countries.

Ideally, not less than 20 per cent (but not more than 40 per cent) of the energy requirement should be supplied from fats and oils. This greatly enhances the palatability of the diet and increases the energy density, and is particularly important for young children. And, ideally, 10–15 per cent of protein should be of animal origin.

The large-scale use of specially formulated ‘high-protein’ foods is rarely justified. Most normal mixed diets, of which sufficient is eaten to provide adequate energy, will also provide sufficient protein. A mixture of different foods is particularly important for children, and helps to ensure good absorption of protein.

Even a growing child, if healthy, requires no more than 10 per cent of total energy intake to be supplied in the form of protein. If energy intake is inadequate, protein will be burnt to provide energy – i.e. it will be used in the same way as carbohydrates and fat (which are usually much less expensive) – not for growth and repair.

**Further Guidance**


Guide to food and health relief operations for disasters, Protein–Calorie Advisory Group, UN, 1977

Management of group feeding programmes, FAO food and nutrition paper 23, FAO, 1982


Control of vitamin A deficiency and xerophthalmia, WHO Technical Reference Series, 672 WHO, 1982

Guidelines for the use of vitamin A in emergency relief operations, International Vitamin A Consultative Group, IVACG technical guide series, 1988


**Panels**

**Panel 1 – Classification of Protein–Energy Malnutrition**

<table>
<thead>
<tr>
<th>CLASSIFICATION OF PROTEIN–ENERGY MALNUTRITION</th>
</tr>
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<tbody>
<tr>
<td>Symmetrical oedema</td>
</tr>
<tr>
<td>Weight–for–height</td>
</tr>
<tr>
<td>(+2 to −1 Z)</td>
</tr>
<tr>
<td>Height–for–age</td>
</tr>
<tr>
<td>(+2 to −1 Z)</td>
</tr>
</tbody>
</table>
1 The diagnoses are not mutually exclusive. A child can have severe wasting and oedematous malnutrition, or severe wasting and severe stunting, etc.

2 This corresponds to the definitions of ‘kwashiorkor’ and ‘marasmic kwashiorkor’ in older classifications. However, to avoid confusion with the clinical syndrome of kwashiorkor, which includes other features, the term ‘oedematous malnutrition’ is preferred.

Panel 2 – Possible Vitamin/Mineral Deficiencies

<table>
<thead>
<tr>
<th>POSSIBLE VITAMIN/MINERAL DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anemia:</strong> Caused by parasitic infections, low intake and/or poor absorption of iron and folic acid.</td>
</tr>
<tr>
<td>Tongue, finger nails and inside of lower eyelids appear unusually pale.</td>
</tr>
<tr>
<td><strong>Vitamin A deficiency (xerophthalmia):</strong> Signs are poor vision in the dark, dryness or foamy material on the white of the eye and/or clouding of the cornea (the dark of the eye). More severe cases lead to ulceration of the cornea.</td>
</tr>
<tr>
<td><strong>Vitamin-B1 deficiency (beri-beri):</strong> Occurs when diet consists almost exclusively of white polished rice or starchy staples such as cassava. Loss of appetite, malaise and severe weakness, especially in the limbs. May also lead to paralysis of the limbs or swelling of the body, heart failure and sudden death.</td>
</tr>
<tr>
<td><strong>Niacin deficiency (pellagra):</strong> Occurs especially where maize and sorghum are the staples and other foods are lacking. Skin rash on parts of the body exposed to sunlight.</td>
</tr>
<tr>
<td><strong>Vitamin C deficiency (scurvy):</strong> Occurs when fruits and vegetable are lacking. Swollen gums that bleed easily; swollen, painful joints.</td>
</tr>
</tbody>
</table>

Panel 3 – Prevention and Treatment of Vitamin A Deficiency

<table>
<thead>
<tr>
<th>PREVENTION AND TREATMENT OF VITAMIN A DEFICIENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention:</strong> Inclusion of yellow fruits and vegetables, eggs, small dried fish, palm oil, dark green leafy vegetables, vitamin A fortified foods in the diet of all children. If these foods are not available provide large dose capsules once every 6 months.</td>
</tr>
<tr>
<td><strong>Treatment:</strong> In all stages of active xerophthalmia, including night blindness and/or when changes can be seen in the eye itself:</td>
</tr>
<tr>
<td>• <strong>immediately:</strong> one 200,000 IU capsule orally for children 1–6 years. Half the dose (100,000 IU) for infants below 12 months or children less than 8 kg;</td>
</tr>
<tr>
<td>• <strong>the next day:</strong> repeat same dosage;</td>
</tr>
<tr>
<td>• <strong>1–4 weeks later:</strong> repeat same dosage.</td>
</tr>
<tr>
<td>In presence of persistent vomiting or very severe diarrhoea, a water–miscible injectable form of vitamin A (100,000 IU) may be substituted for the first dose (syringes and needles must be sterile). In cases where changes can be seen in the dark of the eye (corneal lesions), the patient should be referred, where possible, to a hospital, but without delaying the above treatment. Children with severe protein–energy malnutrition and xerophthalmia must be carefully monitored, and may require additional doses.</td>
</tr>
</tbody>
</table>
Chemoprophylaxis:

The occurrence of night blindness in 1 per cent of children aged 6 months to 6 years – or of Bitot spots in 0.5 per cent – indicates a public health problem. If such data are not available, the mortality rate of children under five years of age can be taken as an indication of whether vitamin A capsules should be provided. In case the under-five mortality is higher than 70 per 1000, then capsules should be distributed.

- One capsule or equivalent of 200,000 IU for each child 1–6 years every 3–6 months. Half the dose to infants 6–12 months or children less than 8 kg;

- One capsule (once only) to women at the time of delivery or within two hours of giving birth.

In communities in which vitamin A deficiency is a recognized problem (or the fatality rate of measles is 1 per cent or higher), all children diagnosed with measles should immediately be given the dose indicated above.

Panel 4a – Agency Recommendation for Energy

<table>
<thead>
<tr>
<th>Agency</th>
<th>Recommendation</th>
<th>Basis of recommendation</th>
<th>Agency recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>WFP, UNHCR, Oxfam, SCF</td>
<td>1,900 kcal minimum</td>
<td>very little activity</td>
<td>Followed as soon as possible by adjustment for activity level, climate, demographic composition, health/nutritional status.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>warm climate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>normal demographic distribution</td>
<td></td>
</tr>
<tr>
<td>ICRC</td>
<td>2,400 kcal target ration</td>
<td>Correlates to the requirements of a moderately active population</td>
<td>Avoids need for supplementary feeding programmes. Adjusted in some circumstances.</td>
</tr>
<tr>
<td>WHO, MSF</td>
<td>2,100 kcal minimum</td>
<td>light activity</td>
<td>To be adjusted as soon as possible by adjustment for activity level, climate, demographic composition, health/nutritional status.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>warm climate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>normal demographic distribution</td>
<td></td>
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Panel 4b – Agency Recommendation Concerning Factors Increasing Energy Requirements

<table>
<thead>
<tr>
<th>Factor</th>
<th>Agency recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than normal proportion of men, pregnant women, or children and adolescent in the population</td>
<td>□ enhanced rations of 2,250–2,325 kcal (UNHCR)</td>
</tr>
<tr>
<td>□ nutritional stress</td>
<td></td>
</tr>
<tr>
<td>□ widespread illness</td>
<td>□ 2,000–2,200 kcal if malnutrition is widespread (WFP, IFRC)</td>
</tr>
<tr>
<td>□ undernutrition</td>
<td></td>
</tr>
<tr>
<td>□ CMR&gt; 1/10,000/day</td>
<td>□ increase the mean population requirement by 20 kcal if &gt;15% malnutrition, by 10 kcal if 10–15% malnutrition, and by 5 kcal if 5–10% malnutrition (WHO)*</td>
</tr>
<tr>
<td>Increased activity levels at certain times of the year or early stages of agricultural settlement of self-sufficiency project.</td>
<td>□ increase cereals by 500g (UNHCR)</td>
</tr>
<tr>
<td>□ increased energy requirements (WFP)</td>
<td></td>
</tr>
<tr>
<td>□ increased requirement by 100 kcal for moderate activity, 150 kcal for moderate/heavy activity, and 250 kcal for heavy</td>
<td></td>
</tr>
</tbody>
</table>
increase requirement by 5% (100 kcal) for every 5 degrees below 20 degrees Celsius (UNHCR, MSF, WFP, WHO) enhanced rations of 2,200−2,400 kcal if population totally dependent on food aid and debilitated, exposed to cold, or engaged in heavy work (WHO, UNHCR, WFP)

Notes:

* Malnutrition defined as weight−for−height below −2 SD of reference population.

** These are additional mean energy requirements for the whole population of adults occupied for 7 hours per day at different activity levels.


Panel 5 – Basic Types of Nutrients

**BASIC TYPES OF NUTRIENTS**

All foods are made up of five basic types of nutrients in addition to variable amounts of water:

The five basic types of nutrients are carbohydrates, fats, proteins, vitamins and minerals:

- **Carbohydrates** are a source of energy, typically providing about 4 kcal per gram. They are mostly starches and sugars of vegetable origin, and constitute the major component of cereals and tubers.

- **Fats and oils** are the most concentrated source of energy, some 9 kcal per gram.

- **Proteins** are body−building substances required for growth and tissue repair. They are found in varying quantities in foods of animal origin, in legumes and, to a lesser extent, in cereals. They also provide energy, about 4 kcal per gram. Protein requirements are normally expressed in terms of ‘reference protein’ equivalent to that of milk and eggs. The real value of the protein in any meal – the quantity actually absorbed – is obtained by adjusting (reducing) the nominal protein content of the constituent food items for ‘digestibility’ and ‘quality’, which in turn depend on the particular mix of amino acids in the meal.

- A variety of proteins and minerals are needed in small quantities for the adequate functioning of the body.

Individual vitamins and minerals or combinations are found in all foods in very variable amounts.

Panel 6 – Average Daily Energy and Protein Requirements of Individuals–Planning Guidelines
Chapter 3: Ongoing Education

Rationale

Education is a fundamental right of all children in all situations. In emergencies, children are frequently denied this right. As a result, they are also denied the opportunity to develop and acquire the skills, knowledge and competencies to better cope with the prevailing difficult circumstances and to contribute to the recovery of their families and communities (see Panel 1).

Educational activities, regardless of where they are conducted, are essential to the normal development of children. In emergency situations, education also:

- plays a critical role in normalizing the situation for the child,
- helps minimize the stresses experienced because of the sudden and violent destabilization of the child’s immediate family and social environment,
- helps children deal with their future more confidently,
- helps make it possible for children to contribute to a peaceful society,
- plays an important role in rebuilding family and community cohesiveness by providing a common project for families and communities to focus on, is critical for initiating the process of social reconstruction.

Average Daily Energy and Protein Requirements of Individuals—Planning Guidelines

<table>
<thead>
<tr>
<th>Energy (kcal/day)*</th>
<th>Protein (g/day)*</th>
<th>Approximate proportions of a typical population*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Recommended</td>
<td>Temporary maintenance</td>
</tr>
<tr>
<td>Infants 4–12 months</td>
<td>1.1 kg body weight (avg. 0.95)</td>
<td>2.1 kg body weight (avg. 1.14)</td>
</tr>
<tr>
<td>Children 1–3 years</td>
<td>1,258</td>
<td>1,200</td>
</tr>
<tr>
<td>Children 4–6 years</td>
<td>1,750</td>
<td>1,500</td>
</tr>
<tr>
<td>Children 7–9 years</td>
<td>2,000</td>
<td>1,800</td>
</tr>
<tr>
<td>Children &gt; 10 yrs. and adults</td>
<td>2,300</td>
<td>2,100</td>
</tr>
<tr>
<td>Additional requirements for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pregnant women</td>
<td>+250</td>
<td>+250</td>
</tr>
<tr>
<td>lactating women</td>
<td>+500</td>
<td>+500</td>
</tr>
</tbody>
</table>

* Energy is sometimes expressed in megajoules (MJ): 1 MJ = 239 kcal

**The first column applies if the diet contains ‘high quality’ proteins - a mixed diet, including some animal protein. The second indicates the minimum quantities required if there is much fibre in the diet and protein is largely provided from cereals with some legumes.

---

Panel 1: Ongoing Education

Rationale

Education is a fundamental right of all children in all situations. In emergencies, children are frequently denied this right. As a result, they are also denied the opportunity to develop and acquire the skills, knowledge and competencies to better cope with the prevailing difficult circumstances and to contribute to the recovery of their families and communities (see Panel 1).

Educational activities, regardless of where they are conducted, are essential to the normal development of children. In emergency situations, education also:

- plays a critical role in normalizing the situation for the child,
- helps minimize the stresses experienced because of the sudden and violent destabilization of the child’s immediate family and social environment,
- helps children deal with their future more confidently,
- helps make it possible for children to contribute to a peaceful society,
- plays an important role in rebuilding family and community cohesiveness by providing a common project for families and communities to focus on, is critical for initiating the process of social reconstruction.
General Aim

• The general aim of UNICEF’s support to education in emergencies is to restore the right to, and promote development of, basic education in the emergency-affected communities.

Emergencies can have serious adverse effects on education:

• Teachers are often not available due to displacement, involvement in armed forces, etc., or are ill-prepared to teach in an emergency environment.

• Looting and burning of educational equipment and materials, and the destruction of schools and other education infrastructure is common.

• Curriculum documentation is often lost or destroyed, and curricula are often rendered inadequate due to the changed conditions and learning needs.

• Recreational and play opportunities are severely limited in most emergency contexts for children who are in as well as out of school.

• Children, especially girls, typically drop out of school during natural disasters and war.

• During a crisis, parents may not be able to pay school fees or make the contributions required for normal functioning of the school system.

• Poverty and fighting often result in physical or developmental disabilities, which hamper their ability to learn.

• War and other trauma situations are major psychosocial stressors for children, with long-lasting effects that influence learning.

• Teachers may also be suffering the effects of psychosocial stress and may require support.

• The education system and schools have often been used for indoctrination purposes and thus may be discredited in the eyes of some communities.

Field Level Strategies

• Mobilize communities to establish basic education services.

• Provide training opportunities for teachers, paraprofessionals and/or community members.

• Ensure the provision of basic educational equipment and materials.

• Reach agreements on relevant curricula, drawing on existing materials wherever possible, but add key life skills.

• Promote recreational and play opportunities.

• Promote the rehabilitation of the educational system, schools and classrooms.

• Advocate for education activities and promote coordination with other agencies.

Basic Principles

UNICEF emergency actions in education are based on the following basic principles.

• Education is a fundamental right of all children in all countries and in all situations. It is essential to the normal development of children in all circumstances. The psychosocial aspects of education and schooling are particularly important to a child’s overall development.

• Regular schooling is one of the most important means of restoring a sense of normalcy to
the lives of children in disrupted communities, and contributes significantly to overcoming the psychological and other forms of distress that many will have experienced.

• In emergencies, children must be able to participate in quality education that includes the key ‘core’ of skills, knowledge and competencies that constitute a basic education in normal circumstances.

• Children in emergencies also should be provided specific, often urgently needed, life skills to survive and cope in the emergency setting; mine awareness and dealing with psychosocial stress are two common examples.

• The entire education system, not just the curriculum, must be gender sensitive and attentive to equity and diversity issues.

• Education programmes in situations of crisis or chronic instability should include provision for the needs of children at risk, such as disabled children, unaccompanied minors, street children, children affected by HIV/AIDS, child soldiers, and child labourers.

• An emergency education programme should have a long-term development perspective and not merely be a series of stop-gap measures. Simple initial steps should be designed to contribute to the ultimate rebuilding of the education system.

• An emergency education programme should help provide society with skills and knowledge to deal with the current emergency and prevent or reduce the severity of future ones.

• Parents and community should be respected key initiators and partners in the educational process. Community resources should be included as part of the ‘package’ of learning materials.

• The right of adolescents to basic education, which may have been disrupted by conflict or emergency, must be taken into account. Non-formal and formal approaches may be used to meet the training needs of youth.

Identifying Priorities

Needs assessment should include:

- community needs
- existing/potential facilities
- life skills/coping
- local resources
- social mobilization

A rapid preliminary assessment should be undertaken by/with the community to identify urgent education priorities. This should be followed up with a more comprehensive assessment of children’s educational needs. Initial assessment should include:

- educational needs of the community:

- number of children (by age and gender) who are in need of primary education
- level of formal/non-formal education of the children
- extent of disruption caused by the situation
- need for any special survival skills
- location of the target groups

- the condition of families, neighbourhoods and communities, and the extent to which they are intact and able to participate in planning and implementing educational activities

- existing or potential education facilities and services, including:
• institutions and organizations (including NGOs) that have the potential to contribute
• educational programmes in place prior to the emergency, both formal and non-formal
• instructional material available
• existing physical facilities that could be used for schooling
• facilities available to support training of staff, curriculum development and production of supportive materials
• recording and broadcasting facilities
• types of ‘coping’ skills that are necessary for children short term and in the transition to a post-emergency state. In both conflict and post-conflict situations, ‘education for reconciliation’ may need to be included.
• local resources, including:
  • individuals able to take on leadership or technical roles in providing educational services
  • individuals and their qualifications who can serve as classroom facilitators (para-professionals) or teachers
  • the level of education of the target community
  • types of social mobilization activities required to provide education under the new circumstances.

Given the rapidly changing conditions that characterize most emergencies, assessment of conditions (see Panel 2) should not be limited to the initial planning period but should be an integral ongoing component of the programme. Annex 1 provides a standardized questionnaire template for an initial needs assessment that may be adapted for use in various country and emergency contexts.

Field-Level Strategies and Actions

Following a needs assessment, the first phase of education programmes should focus on what can be done rapidly to support local initiatives to restart classes for children. This is to ensure that children do not miss essential educational opportunities and so that they can have the psychosocial benefits of schooling. The initial response must address specific local needs of school-age children. Activities should begin as soon as possible, even if very simple, basic materials are not available.

Community/Group Mobilization

Mobilizing and supporting community action to establish basic education services should be the immediate priority of an emergency education programme. The inclusion of communities themselves in responding to the need for education services during an emergency sets the stage for continuous action once the crisis is over. A participatory approach helps recreate a sense of ‘community’, and develop the competence, confidence and will that leads to sustained and responsible collective action for addressing community problems, issues and concerns. General intervention options include the following:

With the community, assess community capacity for establishing basic education services: Assess the physical, material, institutional and human resources at the community’s disposal. This should provide a clear picture of community strengths and help determine what can be mobilized internally and what will need to be solicited externally.
Develop a community profile: Identify traditional methods for involving people, decision-making structures, persons and groups likely to take action, those interested, and those who do not care. Establish working alliances accordingly.

Organize with the community, training/sensitization workshops: These should promote the benefits of education for children and the community as a whole, and to identify key concerns of parents and other community members (e.g. safety, continuity of the education programme).

Promote community participation: Communities should be involved throughout in the initiation, planning and implementation of basic education services and the rebuilding of the education system. Emphasis should be on the other priority concerns listed above (i.e. teacher mobilization and training, basic equipment and/or materials, curricula availability and relevance, play and recreational opportunities, and educational facilities). Support the creation of parent and community associations to help organize efforts that can be ongoing and are locally sustainable.

UNICEF’s emergency response should address the following concerns:

- the need for community/group mobilization in support of reactivating primary education;
- the need for parent involvement;
- insufficient number of qualified teachers;
- insufficient basic equipment and/or learning materials;
- unavailable or inadequate curricula;
- lack of play and recreational opportunities
- gender issues in educational provision
- unusable or damaged educational facilities.

Teacher mobilization/training

In emergency situations qualified teachers are often not available or are ill prepared to function effectively. New teachers then need to be rapidly recruited among community members who are still present at the emergency site.

Teacher training activities must be organized to prepare both new paraprofessionals and existing professionals to face the demands of teaching in an emergency context. Adult leadership and support is very important, especially in the early stages of an emergency, and those selected as teachers/facilitators should also be mobilized and prepared to play a broader community leadership and support role (teacher training is dealt with in more detail in Annex 2).

General intervention options include the following:

Identify and mobilize any community members who are qualified or have experience in teaching: Most communities will have a few persons with previous teaching experience who can play a leading role in teacher preparation.

Identify and mobilize community members to act as teachers/facilitators: Design simple pre- and in-service training activities to equip them with the minimum knowledge and skills required to provide basic education; ensure training on the use of education kits if they are to be used.

Offer extra incentives where needed: These can be either monetary or in-kind support to attract teachers to work in adverse conditions and to help recruits meet their own or their families emergency needs so they can focus on the needs of the children. In general, avoid presenting incentives as salaries, and try to ensure equity with incentives paid in comparable activities in the area.
Identify older children/adolescents, where necessary: Find those who have leadership and basic teaching capabilities to assist in teaching younger children.

Train teachers and parateachers in psychosocial support: Base this on culture- and community-specific mechanisms for dealing with psychosocial stress and trauma (see Chapter 14, “Protecting Psychosocial Development” for further details).

Use trained teachers: Mobilize them as ‘leaders’ of clusters of paraprofessional teachers.

Ensure the restarting of teacher training courses: Reactivate training when institutional services have been disrupted, to guard against future teacher shortages. Because of the costs of institutional teacher training, explore options such as supervised apprenticeships and attachments to master teachers.

Basic equipment and/or materials

<table>
<thead>
<tr>
<th>Essential resources include, in order of priority:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• blackboards and chalk</td>
</tr>
<tr>
<td>• exercise books, pens, and pencils</td>
</tr>
<tr>
<td>• manuals for teachers</td>
</tr>
<tr>
<td>• textbooks for students</td>
</tr>
</tbody>
</table>

During conflict situations, looting and burning of educational equipment and materials is common. In such times, not only is the government often unable to invest in this area, but most families are not in a position to cover any educational costs. Yet, the provision of basic equipment and materials, however minimal, is critical to the re-establishment of educational services.

• Intervention options include: With the community, identify the key basic supplies necessary to restart primary education, and assist in procurement, where possible from local sources. Where used, education ‘kits’ should be assembled on the basis of the community input.

• Where urgency necessitates the importation of initial basic kits in the first phase, involve communities and school personnel in determining how the initial basic kits should be supplemented and adapted for local conditions.

• Support for the local production of learning materials and training guides wherever possible. Community should be involved in organizing and establishing these efforts.

• Facilitation of the local development of reading materials (using ‘copykits’ as one option, as described in Annex 3).

Curriculum Development

Educational kits

Educational kits represent an important part of UNICEF’s initial response to these priority concerns in many emergency contexts. First introduced by UNESCO and UNICEF in Rwanda and Somalia, the aim of ‘edukits’ is to provide the basic educational materials essential to initiate primary education. The content of edukits is dynamic – responding to a specific environment and changing needs, and using field-tested materials. Kits must be supplemented by a participatory of curriculum and teacher development.

In many emergencies, course curricula and accompanying materials are lost, necessitating the rapid institution of new curricula relevant to local needs. Curriculum development is a highly political and therefore consultative process, and a guiding principle should be to build on what is available and familiar to teachers, students and communities except where changes are unavoidable. In post conflict situations, curricula may be discredited or have sections that are not acceptable to communities. In some cases, the changed circumstances and emergency impact may create or highlight critical learning needs not covered in existing curricula, necessitating curricula redesign or the addition of new curricula components. For example, in emergencies, children are often traumatized by tragic events they have to face or witness, and they often suffer the loss of a family member or acquaintance.
Generally, pre-existing curricula do not help children cope with such situations. An emergency situation may also require new survival skills, such as mine awareness or cholera prevention. The following are some of the key elements to consider including in curricula during an emergency.

**Materials/activities addressing grief and psychosocial stress:** There is no single right way to approach this topic. Societies, communities and, indeed, families each have developed their own unique ways for dealing with loss and stress. These need to be identified and utilized to enable children, parents and teachers to come to terms with their experiences and cope with their new circumstances (see Chapter 14, “Protecting Psychosocial Development”).

**Mine awareness:** Mines are major killers of children, and schools are often targeted in conflict situations. As an immediate priority, children, teachers and communities must be taught to be watchful and know how to get assistance when mines are located (see Chapter 6, “Anti-Personnel Landmines”).

**Health and healthy lifestyles awareness:** Emergencies often result in the breakdown of many normal structures and controls. Even where previously health standards were high and clean water was available this may no longer be the case, making good education about topics such as sanitation and cholera critical. Infection rates of diseases such as HIV/AIDS and other sexually transmitted diseases need to be considered and accurate information about prevention and protection made readily available (see Chapter 1, “Protecting and Promoting Health” and related annexes).

**Emergency curricula should include components related to:**
- grief/psychosocial stress
- mine awareness
- health/lifestyle
- peace education/conflict resolution

**Peace education:** Peace education in UNICEF refers to the process of promoting the knowledge, skills, attitudes and values needed to bring about behaviour changes that will enable children, youth and adults to prevent conflict and violence, both overt and structural; to resolve conflict peacefully; and to create the conditions conducive to peace, whether at an intrapersonal, interpersonal, intergroup, national or international level.

This definition represents a convergence of ideas that have been developed through the practical experiences of UNICEF peace education programmes in a number of countries. These programmes are highly responsive to local political and cultural circumstances. No one approach to peace education is universally used.

Peace education is an integral part of the UNICEF vision of quality basic education. While often based in schools and other learning environments, peace education should ideally involve the entire community.

Because lasting behaviour change in children and adults only occurs over time, effective peace education is necessarily a long-term process, not a short-term intervention. It is UNICEF’s position that peace education has a place in all societies – not only in countries undergoing armed conflict or emergencies.

Peace-building initiatives may be perceived as highly political and sensitive, and should be undertaken in close partnership with a good cross-section of interests in the community. Make use of indigenous strategies for managing grief and conflict, and use or adopt local materials, poems, songs, etc.

**Educational Needs of Specific Populations**

In conflict situations, it may be necessary to develop some very targeted educational activities for the following special populations (see specific chapters for more detail).

**Child soldiers:** Decreasing the incidence of child soldiers in conflict will take coordinated effort. Education must play a key role in demobilization. The challenge is to provide basic education tailoring a programme that allows children to reassume the childhood that has been stolen from them.

**Early childhood care and development:** Organized educational activities can serve as an excellent location for the provision of early childhood care and development. This is a key part of early learning and such activities can free up girls to access their right to basic education, as they are often responsible for sibling...
 Girls: Because of well-established historical gender bias and because normal social norms and actions break down during emergencies, girls are usually at particular risk. Their already heavy workloads increase at the same time as their physical and emotional safety is further compromised. They are often the first to be deprived of their educational rights. Planned educational activities must take this into account and address related issues through such things as adult education, the curricular content and processes, and providing a safe learning environment for girls.

 Disabled and children with special learning needs: Provision must be made in planning the education response to ensure inclusion of disabled children and children with special learning needs.

 Adult education: Special attention needs to be given to parenting education, life skills and education for women that will support them in re-establishing households and livelihoods under emergency conditions.

 Peace-keeping forces: It may be necessary to provide public education to peace-keeping forces concerning children's rights and, as peace-keepers, their obligation to protect and care for children.

 Youth and adolescents: Work with community and other agencies/donors/NGOs to identify strategies for formal/non-formal approaches to basic education for adolescents and youth above normal basic education age, encourage other actors to support secondary and vocational training opportunities.

 Rehabilitation of facilities

 Emergencies often result in the disruption of educational services and the destruction of schools. Although classes may sometimes be held in the open air, this may not protect the newly acquired equipment and/or materials. In certain climates, children require protection against the sun, cold, strong winds, dust and rain, making the construction of some kind of shelter necessary. Psychologically, educational facilities are often perceived by children as a safe sanctuary where shooting and other forms of violence are unlikely to occur. Thus, at some point in time, usually after immediate survival needs are met, the construction/rehabilitation of semi-permanent, or permanent school buildings in close partnership with communities (where possible) may become a necessity. Supplying materials to support community effort is usually a more cost effective approach.

 Intervention options include the following:

 - Selection of safe, secure sites for the establishment of temporary classes, with shade and protection against wind, rain and dust, and removed from stagnant water, main roads and distribution points.

 - Provision of tents or essential materials and/or tools to enable immediate, preliminary repairs to school premises needed for shelter.

 - Provision of materials and/or tools for reconstruction/rehabilitation of primary schools and teacher training institutions, with a particular emphasis on the replacement of furniture and basic equipment.

 - Promotion of alternative classroom models, e.g. the BRAC model, where classrooms are without desks and students sit in a circle instead.

 Coordination and Partnerships

 Recreation and Play

 These are severely limited in most emergencies, denying all children a key means of dealing with psychosocial stress and establishing a semblance of normalcy in their lives. Safe play areas where children can interact with their peers are critical. See Chapter 14 for details on recreation and play as tools for promoting psychosocial recovery.
Emergency action should be conducted in close conjunction with the Office of the United Nations High Commissioner for Refugees; UNESCO and NGOs in relation to refugees and displaced people; and with UNESCO, UNDP, the World Bank, the World Food Programme, and NGOs with regard to other emergency–affected populations.

If possible, an inter–agency team should be formed. The team, under the leadership of one of the agencies, would then use agreed upon guidelines to coordinate the work and ensure that the different activities are carried out in a logical order. Key areas for agreement include:

- Minimum qualifications for teachers and paraprofessionals;
- Common policy or teacher ‘incentives’;
- Transparent processes for teacher selection.

Panel 4 provides the principles of cooperation in education between UNHCR, UNESCO and UNICEF.

**Panels**

**Panel 1 – What is Basic Education?**

<table>
<thead>
<tr>
<th>WHAT IS BASIC EDUCATION?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic education consists of a combination of indispensable competencies, knowledge, skills, and attitudes that serve as the foundation of any individual’s life–long learning. Although there will be differences in what constitutes ’basic education’ from society to society, there are some fundamentals that are common across cultural, social and political boundaries.</td>
</tr>
<tr>
<td>Key competencies include reading, writing and numeracy. Without these competencies, it is difficult for an individual to pursue learning in modern times.</td>
</tr>
<tr>
<td>Knowledge should be both theoretical and practical. An example is the area of basic science. Its content, for instance, will likely vary according to the particular context, but it must provide learners with the basic scientific concepts and experience that will allow them to function on a daily basis in such areas as food, nutrition, water, and sanitation.</td>
</tr>
<tr>
<td>Basic skills provide an individual with the ability to use knowledge effectively and easily. There are many different types of skills. Survival skills are those that are basic to survival, such as finding food and seeking protection.</td>
</tr>
<tr>
<td>Life skills enable an individual to access a better life. These might include skills for work, problem–solving skills, communication, analysis and logic.</td>
</tr>
<tr>
<td>Attitudes are feelings about or positions towards certain purposes or aspects of life. These include self–esteem, tolerance, cooperation, and civic responsibility.</td>
</tr>
<tr>
<td>Thus, basic education is a broad and complex concept. Although there is general agreement as to what the components are, there is plenty of room for each country and community to configure these components in ways that are most relevant to them. In operation, basic education occurs in a wide range of contexts and is not limited by structure, content or participants.</td>
</tr>
</tbody>
</table>

**Panel 2 – Conditions Needed for Implementing Education in Emergencies**

<table>
<thead>
<tr>
<th>CONDITIONS NEEDED FOR IMPLEMENTING EDUCATION IN EMERGENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• an organizational structure is in existence, or emerging, identifying the affected populations in units;</td>
</tr>
<tr>
<td>• an expressed interest for children’s education;</td>
</tr>
</tbody>
</table>
Panel 3 – Teacher Emergency Package (TEP)

**TEACHER EMERGENCY PACKAGE (TEP)**

TEP is designed as a quick-response, self-sufficient ‘classroom’ to address many of the immediate education priorities confronting emergency-affected communities. Developed jointly by UNESCO and UNICEF, it has already been used successfully in a number of emergency settings. Its contents are as follows.

At a practical level it provides all the materials necessary for a class of 40 students and a teacher per class (shift), even where buildings do not exist. The kit contains:

- 40 slates and 7 boxes of chalk;
- 40 pencils, erasers and 80 exercise books;
- a Teachers’ Guide with day-by-day lessons for a six-month emergency literacy and numeracy programme and an activities book;
- storybooks published jointly by UNESCO and Longmans;
- paint and brush to improvise a blackboard;
- a supply of chalk and a duster;
- washable cloth charts displaying numbers, letters of the Kinyarwandi alphabet, a multiplication table, etc.;
- 10 Scrabble® sets for 40 children to sit around and play with;
- a permanent marker to write letters and numbers on a dice;
- a measuring tape; and
- an exercise book, an attendance book, a few pencils, an eraser, and a pencil sharpener.

At a support level, the Teachers’ Guide provides teachers with structured lesson plans in basic literacy and numeracy, which enable them to teach children even if they are untrained or semi-trained.

At a psychological–emotional level, TEP provides the children with a stability of environment that may otherwise be non-existent. It allows for continuity of schooling in their home language even though the children are displaced and provides illustrations of their culture through stories, songs and games.

Source: UNESCO/ Programme for Emergency Education and Rehabilitation (PEER), 1994
• Education is essential.

• Major emergencies require clear directions and indicators.

• The initial response must address the specific local needs of school−age children.

• The approach to emergency education must have the longer−term view of rebuilding the education system.

• Cooperation among agencies is essential and requires a joint committee/technical unit.

• The accepted view of education must be child−based.

• There must be direct and, if possible, unbroken links between refugee camps and later settlement locations.

• The first agency operating in the field must collect educational statistics to facilitate planning.

• There is a need for simple guidelines on how to get started/where to look for support.

• Special attention must be paid to girls and adolescents.

• Adolescents must be brought into the process as early as possible.

• ‘Second chance’ or ‘drop−in’ education for adolescents should be a component of EDEM.

• There is a need for agreed−upon mechanisms for working with NGOs.

• There is a need for agreements on salaries/payment for work.

• Education in emergencies must be more than kits; it must include, for example, training, dealing with trauma and community−building.

• Curriculum issues may need special attention, particularly with regard to the relevance of the ‘former’ curriculum and language policies. A long−term view is necessary.

• Speedy identification of local skills and capacity is necessary.

• Teachers and teacher training are especially important in relation to emergency situations.

• If vocational skills are considered part of EDEM, particular attention must be paid to output and likely opportunities.

• Educational content must include basic life skills that are particularly necessary in the existing emergency.

• Health campaigns should remain the responsibility of health workers.

Source: Inter−agency Consultation on Humanitarian Assistance and Refugees, Geneva, 9−11 May 1996.
<table>
<thead>
<tr>
<th>Location(s):</th>
<th>Nature of Emergency:</th>
</tr>
</thead>
</table>

**Main Problem(s):**

**Are some schools still functioning?**

<table>
<thead>
<tr>
<th>Yes/No</th>
<th>Location(s)</th>
<th>Number of children attending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Girls</td>
</tr>
</tbody>
</table>

**1. Main cause(s) and/or manifestation(s) of problem:**

- School buildings have been damaged
- Water on school premises is unsafe/not available
- Teachers will not work if unpaid
- Teachers are not paid
- Teachers have left or are afraid
- Teachers have left or are afraid
- Traveling has become dangerous
- Traveling has become dangerous
- Teachers are enrolled in army
- Teachers are enrolled in army
- Teachers are enrolled in army
- Some children have been traumatized
- Some children have been traumatized
- Some children are disabled
- Some children are disabled
- Children are enrolled in army
- Children are enrolled in army
- Lack of educated adults to replace teachers

**2. Identification of Children Population**

<table>
<thead>
<tr>
<th>Number of children</th>
<th>Total</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-5 year olds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-13 year olds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14-18 year olds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-movers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**3. Comparison with Pre-Emergency Situation**

<table>
<thead>
<tr>
<th>Total</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-5 year olds</td>
<td>Less</td>
<td>Same</td>
</tr>
<tr>
<td>6-13 year olds</td>
<td>Less</td>
<td>Same</td>
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</tr>
<tr>
<td>Residents</td>
<td>Less</td>
<td>Same</td>
</tr>
<tr>
<td>In-movers</td>
<td>Less</td>
<td>Same</td>
</tr>
</tbody>
</table>

**4. What is the children’s level of education?**

- Early childhood education
- Primary education
- Middle school education (early adolescents)

<table>
<thead>
<tr>
<th>% of age group</th>
<th>Early childhood education</th>
<th>Primary education</th>
<th>Middle school education</th>
</tr>
</thead>
<tbody>
<tr>
<td>population that have completed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**5. What is/are the language(s) used by the children?**

<table>
<thead>
<tr>
<th>Mother tongue</th>
<th>Spoken</th>
<th>Written</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local languages (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**6.a Do you possess a map of the region on which community buildings (e.g. schools, health centers, churches) are indicated?**

**6.b If the answer to 5.a is no, could you obtain one?**

**6.c If the answer to 5.b is no, indicate how to obtain this information**
7. What locations can be used for classes?

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of children that can be accommodated</th>
</tr>
</thead>
<tbody>
<tr>
<td>School/Classrooms</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Center</td>
<td></td>
</tr>
<tr>
<td>Shelter</td>
<td></td>
</tr>
<tr>
<td>Outside (shade, tree...)</td>
<td></td>
</tr>
<tr>
<td>House</td>
<td></td>
</tr>
<tr>
<td>Religious buildings</td>
<td></td>
</tr>
<tr>
<td>Clinics</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
</tr>
</tbody>
</table>

8. Are the following facilities easily accessible?

<table>
<thead>
<tr>
<th>Facility</th>
<th>On-site</th>
<th>At a distance (meters)</th>
<th>Not accessible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water Source (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lavatories</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Showers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilities for the disabled</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. How far would children have to travel to attend classes?

<table>
<thead>
<tr>
<th>Distance (in meters)</th>
<th>0-25%</th>
<th>26-50%</th>
<th>51-75%</th>
<th>76-100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>500 meters or less</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 to 1000 meters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 1000 meters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Distance (in miles)</th>
<th>0-25%</th>
<th>26-50%</th>
<th>51-75%</th>
<th>76-100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/2 a mile or less</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/2 to 1 mile</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 1 mile</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Are children involved in household chores or any other work?

<table>
<thead>
<tr>
<th></th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mainly a.m. or p.m.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11. What is the quantity (approximately) of learning materials that are available and required?

<table>
<thead>
<tr>
<th>Item</th>
<th>Available</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Textbooks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>subject 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>subject 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>subject 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slate(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chalk(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ball sponge(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercise book(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pen(s)/Pencil(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pencil eraser(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Color pencils</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. What is the quantity (approximately) of teaching materials that are available and required?

<table>
<thead>
<tr>
<th>Item</th>
<th>Available</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guides/ Manuals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Record books</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blackboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chalk box(es)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wall charts/maps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pens/Pencils</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stationery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recreational materials</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. Who is/might be available to teach children?

<table>
<thead>
<tr>
<th>Role</th>
<th>No.</th>
<th>Women (%)</th>
<th>Men (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trained teachers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Para-professionals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionals from other fields (e.g. medical/para-medical)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community members</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NGO members</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
14. Who adult human resources are available to support teachers?

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>Women (%)</th>
<th>MEN (%)</th>
<th>Level of education/Qualification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Para-professionals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionals from</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>other field (e.g.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>medical/para-medical)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community members</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NGOs members</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. Are children accompanied?

<table>
<thead>
<tr>
<th></th>
<th>% of children group</th>
</tr>
</thead>
<tbody>
<tr>
<td>By their whole family</td>
<td></td>
</tr>
<tr>
<td>By at least one parent</td>
<td></td>
</tr>
<tr>
<td>By older siblings</td>
<td></td>
</tr>
<tr>
<td>By other family members</td>
<td></td>
</tr>
<tr>
<td>By community members</td>
<td></td>
</tr>
<tr>
<td>By volunteers</td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td></td>
</tr>
</tbody>
</table>

16. Who is the household head?

<table>
<thead>
<tr>
<th></th>
<th>% of children group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
</tr>
<tr>
<td>Other Adult (specify)</td>
<td></td>
</tr>
<tr>
<td>Other Child (Elder sister)</td>
<td></td>
</tr>
<tr>
<td>Other Child (Elder brother)</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
</tr>
</tbody>
</table>

17. Economic background of the children’s family?

<table>
<thead>
<tr>
<th></th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farmers</td>
<td></td>
</tr>
<tr>
<td>Artisans</td>
<td></td>
</tr>
<tr>
<td>Nomads</td>
<td></td>
</tr>
<tr>
<td>Cattle raisers</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
</tr>
</tbody>
</table>
Chapter 3 – Annex 2: Guidelines for Teacher Training

The existing resources will very much determine the extent to which teacher training is necessary and the types of support that will be needed to plan for. These guidelines assume a very basic level of human and infrastructure resources. They can be adapted, or the initial steps completely ignored, in situations where the resource base is fairly strong.

Major steps:

- Determine if those who are willing to serve as teachers have other time-consuming responsibilities as well. If so, consider how to build flexible education schedules to enable them to meet these as well as teaching responsibilities.

- If the teachers are not well known to you, or if you are faced with using a large number of paraprofessionals, begin with a simple literacy test – this way you can place the right people in the right kinds of jobs.

- Determine if the curriculum, syllabus and teachers’ guides are available and appropriate for use.

If they are available, what adaptations will need to be made to meet the current circumstances? For example, should they be simplified because it is mostly paraprofessionals who are available or should there be information added on such topics as mine awareness?
If they are not available, identify teachers and individuals (from teacher training colleges, universities, Ministry of Education, for example) who could do the necessary professional work to develop a temporary curriculum, syllabus and teachers’ guides. As input to this process, you might include examples from another country or situation.

If they are available but not in the necessary language, identify and engage translators who have demonstrated their skills in accurate translation.

If there are plenty of well-trained teachers available:

- Work with them to develop creative ways of providing learning opportunities in the new conditions. This may involve engaging some of them in developing materials, others in identifying sources of locally available educational supports, and still others in working with parents to ensure that children are allowed to participate, for example.

- Encourage them to begin searching for ways to involve parents, community members and interested paraprofessionals in the learning activities of the children.

- Attempt to discover the various strengths of teachers in a particular community. Some teachers are very good at math, others at organizing, others at working with ‘troubled’ children, for example. The extent to which you can use the skills of individuals where they are most needed will make your overall job much easier.

Where there are not many trained teachers available:

- Work with trained teachers to encourage them to view paraprofessionals as colleagues who have needed skills and who can be helpful.

- Use local and international specialists, including local teachers to develop a teacher training programme and materials package for use with paraprofessionals.

- It may be useful to divide the paraprofessionals into different groups according to levels of expertise. For example, secondary school graduates may be better able to work with the content of curriculum designed for older children than those who only have a few years of primary education. Those who are not literate may still have a lot to offer in terms of facilities maintenance and management, enrolment records (through simple community mapping techniques such as those developed in Uganda), or as teachers’ aides, especially if there are likely to be large classes or classes with children of differing age and ability.

- Try to determine if there are some trained teachers who can be immediately used to work with para-professionals, even training them on a daily basis in preparation for the next day’s classes.

- Identify simple mechanisms for a few individuals to serve as ‘pedagogical supports’ to paraprofessionals. These people would observe classes, provide guidance to paraprofessionals, and assist with quality assurance.

For all teachers and paraprofessionals:

- Provide short-term introduction to the goals and objectives of the education programme.

- Design an in-service training programme to support teachers in their work. It will probably be most expedient to develop a simple but regular set of meetings so that teachers can support each other in what will be difficult teaching conditions. Within the training, address such issues as conflict resolution, alternative classroom organization strategies (such as children working in groups, sitting in a circle rather than in rows, peer support activities, etc.), and problem-solving approaches.

- If children and teachers have been subjected to conflict or other trauma, provide short-term training related to this. It is important to acknowledge that teachers will have to recognize and address their own trauma and stresses before they are able to be supportive of children. The Child Protection Section should be helpful in this regard.
• If the emergency appears to be protracted, work with the teachers, particularly the paraprofessionals, and the education authorities to design a longer–term training programme that can have certification attached to it.

• Include training on classroom management and on gender issues in the learning environment.

• Soon after classes are up and running, begin to involve all participants in assessing how things are going and how they might be adapted to improve the situation for the children, teachers and communities. This assessment process is very important for both the quality of education and for building community cohesion around the education process.

• Develop simple mechanisms for collecting and updating data on children, in and out of school, teachers, and other resources that can contribute to the re–establishment and further development of primary education.

Work with all those providing primary education to:

• Determine how to build team approaches to primary education. This might involve short workshops on ‘things that have worked’ or ‘clustering’ para–professionalled classes around those led by ‘master’ teachers.

• Identify incentives and motivation for improved performance. Often motivation has more to do with the ability to make decisions in and around the classroom than with an increase in salary.

• Develop trust among all those engaged in primary education. This includes recognition of the difficult circumstances under which they are working and increasingly trusting the judgement of head teachers and teachers.

• Establish early agreements with all other partners working with teachers and paraprofessionals on qualifications, incentives, gender parity, selection criteria, etc.

Chapter 3 – Annex 3: Educational Kits (Edukits)

The development of Educational Kits (Edukits) was initiated by UNESCO and UNICEF in Rwanda and Somalia, as a means to help children of these countries access or pursue their primary education. ‘School in a box’ was first viewed as a basic rapid response that allowed the delivery of essential learning and teaching materials to places where educational services had been disrupted due to sudden severe situations such as war, civil strife or natural disaster. One of the lessons from this early experience was the local specificity of even quite basic supplies, so that initial kits should contain the absolute basic materials that will enable the resumption of learning. These can then be supplemented and adapted to suit the local curriculum and conditions.

UNICEF Education Section, EMOPS and Supply Division are now finalising the latest revision for two rapid response kits (education, recreation) and working on the development of a kit for early childhood care. The content of edukits is seen as being dynamic, responding to a specific environment and changing needs, and using materials that have been shown to work well in field situations. Items such as wall charts with specific messages may be included, providing for instant information on cholera in areas where this is a health risk, or on mines awareness where conflict has resulted in the placement of landmines. The overall concept is described in more detail below.

The standardised Education Kits and Recreation Kits were developed to ensure quick delivery of basic learning materials in a rapid response situation, and should be regarded as a first response only. In consultation with the local community these kits should be supplemented with locally relevant materials as soon as possible.

In longer term situations of instability locally developed kits often replace the rapid response kits. These kits should, wherever possible, be locally procured, and should avoid items, which cannot be replaced with locally obtainable materials.
Kits for primary education. The education kit consists of two sets of basic materials for classes of approximately 80 students (assuming double sessions of 40) and the teacher/facilitator. The ‘consumables’ are for the learner to use. They include such items as slates, chalks, exercise books, number charts, pencils, and erasers.

Currently the contents of the standard Education Kit are as follows:

<table>
<thead>
<tr>
<th>Students’ Materials</th>
<th>Quantity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 Crayon, wax/BOX–8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100 Eraser, soft, for pencil</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100 Book, exercise, squared</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100 Book, exercise, ruled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100 Pencil sharpener</td>
<td></td>
<td></td>
</tr>
<tr>
<td>144 Pencil for slate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>144 Pencil, HB grade, black</td>
<td></td>
<td></td>
</tr>
<tr>
<td>80 Bag, carrier</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Ruler, 30 cm/SET–10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 Scissors, safety, B/B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50 Slate, student’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 Scissors, safety, B/B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50 Slate, student’s</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Teacher’s Materials</th>
<th>Quantity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Pen, black</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Pen, red</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Pen, blue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Chalk, colours/BOX–100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Chalk, white/BOX–100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Book, exercise, A4, ruled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Pens, felt-tip/SET–6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Paint, chalkboard, black</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Register, A4, squared</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Bag, hand, blue nylon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Triangle, 30–60–90 deg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Triangle, 90–45 deg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Clock, teaching, wood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Scissors, sharp, 180mm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Tape, measure, 5m</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Brush, paint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Box, for storage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Posters/SET–3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Compass, 40 cm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Ruler, 100 cm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Cubes, coloured/SET–100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Duster/Wiper</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The second set is the responsibility of the teacher/facilitator and/or the community, and constitutes the ‘classroom–based’ materials. It includes chalk, atlas, blackboard, geometric instruments, calendar, scissors, etc. Textbooks, charts, maps and other educational materials may vary from country to country according to the national curriculum and specific situation and needs. Each kit also contains simple guidelines for care and use of the kits.

Recreation kits. These kits have been developed to facilitate recreation activities among children affected by crisis. Children often often make their own toys and equipment for games, and these supplies should be used
to supplement rather than replace the indigenous materials. The kit is designed for use by girls as well as boys. The current contents of the standard rapid response recreation kit are as follows:

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Box, metal, lockable, for storage</td>
</tr>
<tr>
<td>3</td>
<td>Book, exercise, A4, ruled—8mm, 96 pages</td>
</tr>
<tr>
<td>12</td>
<td>Pen, ball–point, black</td>
</tr>
<tr>
<td>1</td>
<td>Chalk, powdered/BOX 3kg</td>
</tr>
<tr>
<td>2</td>
<td>Whistle, referee’s, non–metallic</td>
</tr>
<tr>
<td>1</td>
<td>Inflating–kit for balls</td>
</tr>
<tr>
<td>1</td>
<td>Tape, measure, 5m length</td>
</tr>
<tr>
<td>2</td>
<td>Slate, student’s, A4 (210x297mm)</td>
</tr>
<tr>
<td>3</td>
<td>Chalk, white/BOX—100</td>
</tr>
<tr>
<td>1</td>
<td>Bag, hand, blue nylon, 23x36x61cm</td>
</tr>
<tr>
<td>1</td>
<td>T–shirt, UNICEF, cotton, large</td>
</tr>
<tr>
<td>1</td>
<td>Cap, UNICEF, baseball, white, cotton</td>
</tr>
<tr>
<td>20</td>
<td>Tabards, coloured (to distinguish teams)</td>
</tr>
<tr>
<td>2</td>
<td>Skittles, SET—10 + 2 balls</td>
</tr>
<tr>
<td>2</td>
<td>Volleyball, professional model</td>
</tr>
<tr>
<td>1</td>
<td>Volleyball net, 9.5x1m, w/o posts</td>
</tr>
<tr>
<td>2</td>
<td>Football, round, junior, synth leather</td>
</tr>
<tr>
<td>10</td>
<td>Ball, sponge rubber, 60–80 mm diam.</td>
</tr>
<tr>
<td>6</td>
<td>Pickets with flags</td>
</tr>
<tr>
<td>2</td>
<td>Handball, senior, synthetic leather</td>
</tr>
<tr>
<td>3</td>
<td>Handball, junior, synthetic leather</td>
</tr>
</tbody>
</table>

**Teacher training and curriculum development workshops.** A workshop resource kit is being designed and developed. It will address such topics as identifying appropriate curricula, agreeing on teacher and curriculum development strategies, and establishing mechanisms to produce or acquire appropriate curriculum and teacher support materials. It will draw on existing materials that have been developed for emergency situations to the extent possible.

**Strengthening local capacity and participation.** Supplies should take into account what is available locally, what can be made or assembled locally, and aim to support locally based supplies and materials in the long run. They are designed to be both educationally sound and to foster a sense of community through student/family ‘ownership’ of selected items. Students, families and community members involved in the programme should be held responsible for taking care of the consumables and ensuring that they are utilized for their intended purposes. This should help bring families and communities into partnership in the education process, thus serving to rebuild community relationships.

**Chapter 3 – Annex 4: Education for Peace and Conflict Resolution**

**Common Conflict Resolution Themes**

Themes from existing conflict resolution education around the world have included:

- communication skills
- dealing with emotions
- respect for self and others
- cooperation
- decision–making, resolving conflicts
- dealing with prejudice
While some of these themes may not seem to have a direct relationship to conflict resolution, educators have found that they build attitudes and skills which are essential to conflict prevention and the peace–making process.

**Communication skills.** Poor communication and misunderstanding are at the root of many conflicts. Effective communication is essential for parties in conflict to obtain accurate information, determine each other’s needs and feelings, and decide upon agreeable solutions. Communication skills include expression, observation and effective listening. Since ways of communicating vary widely from culture to culture, skills must be appropriate for a given cultural context.

**Dealing with emotions.** It is important for children to learn to identify their own and others’ emotions, to learn to express emotions appropriately, and to respond effectively to emotions of others. How emotions are expressed, particularly anger, can either escalate or de–escalate a conflict. When young people have the ability to discuss what they are feeling and why, they may discover new options for handling those feelings, rather than resorting to violence. While suitable ways of expressing feelings will vary from culture to culture, they have a role to play in the prevention and peaceful resolution of any conflict.

**Respect for self and others.** It has often been observed that people who respect themselves and have positive attitudes about their own self–worth are more likely to also treat others with respect. By contrast, children who appear to have negative or low opinions of themselves have a tendency to be involved in conflicts, and are less likely to resolve conflicts peacefully. Respect for one’s self and others are interrelated, and both are relevant for the process of conflict resolution.

**Cooperation.** Methods to build cooperative behaviours are critical. Most programmes include developing cooperative skills as part of either their content or methodology or both. Research shows that cooperative learning methods promote higher levels of thinking skills than competitive or individualistic methods. They also build good relationships, a sense of group cohesion, promote problem–solving skills and can create a climate in which conflicts are less likely to occur.

**Decision–making skills.** The ways that decisions are made are closely linked to issues of peace and conflict. When decisions are made by an authority figure, without the input of the people affected, the likelihood of dissatisfaction and conflict is increased. When people have an opportunity to express their needs, interests and values, they are more likely to feel satisfied and to accept the constraints necessary. This is true in groups of all kinds–families, schools, communities, and countries.

**Resolving conflicts.** This theme attempts to recognize and integrate the socials skills previously discussed. Using these skills, basic concepts about the nature of conflict, different conflict resolution styles, and situations for which they are most appropriate can be explored.

**Dealing with prejudice.** A critical part of education for conflict resolution is helping young people make a commitment to work towards the reduction of prejudice and towards equal rights for all groups in society. In order for this to happen, young people need:

- knowledge of what stereotypes are and how they are formed,
- sensitivity to the emotional impact of prejudice and all forms of discrimination including gender,
- the opportunity to practice new ways to challenge bias.

**Interpersonal versus Social and Political Conflict**

The focus of conflict resolution programmes is on interpersonal conflicts and the interpersonal skills necessary to resolve such conflicts. This is not to minimize or overlook the impact of wider social and political issues on conflict situations. Clearly, not all conflict is due to inadequate interpersonal skills. Efforts to create more peaceful societies must also address issues of social and political injustice, lack of opportunity for democratic participation, poverty, militarism, and a host of other issues. But developing programmes to teach a range of conflict resolution skills to young people is an important contribution that educators can make, within the context of their profession, to the peace–making process.
At least some of the skills and processes involved in the resolution of interpersonal conflict can be applied to larger social and political conflicts. It is essential that the trainer be aware of the broader conflicts that participants may be dealing with in their communities, and allow them to draw parallels between interpersonal and social conflict resolution processes as they arise.

UNICEF and Education for Development

Education for Development, now accommodated within the Education Section of the Programme Division, has focused its work on:

- producing training materials,
- conducting training workshops,
- providing country specific technical support.

A training manual ‘Education for Conflict Resolution’ was produced in 1996. The manual:

- was piloted in 43 countries, both industrialized and developing;
- draws upon activities used in conflict resolution programmes around the world;
- is intended for use in the training of trainers and others who will design and implement conflict resolution education programmes for young children in the formal and non-formal educational sectors;
- explores strategies for teaching about communication skills, handling emotions, self-awareness, cooperation, decision-making, conflict resolution, and dealing with prejudice;
- includes a section on programme planning in which trainers evaluate the appropriateness of the activities for their own cultural context and design a country-specific teacher training programme;
- is available from the Education Section, Programme Division, UNICEF, New York.

More recently, the Education Section has produced a Working Paper on Peace Education which provides an overview of Peace Education programmes in UNICEF, analyses trends and provides a more coherent framework for work in peace education. This is also available from the Education Section, Programme Division, UNICEF New York.

Chapter 4: Children Separated from Families

Rationale

Few threats to a child’s well-being and long-term development equal that of being unaccompanied. Involuntary separation from both family and community protection, sometimes across national borders, greatly increases the child’s risk of exposure to violence, physical abuse, exploitation, and even death. Surviving children face malnutrition, illness, physical and psychosocial trauma, and impaired cognitive and emotional development. Unaccompanied girls are at especially high risk of sexual abuse, and boys, of forced or ‘voluntary’ participation in violence and armed conflict.

General Aims

- Reunite each unaccompanied child with his/her family as quickly as possible;
- Ensure the survival, protection and well-being of children through interim care;
• Assure care meets the emotional, psychological and developmental needs and is appropriate to the culture of each child;

• Arrange appropriate long-term care when reunification cannot be achieved within a reasonable period of time.

It has been estimated that unaccompanied children make up at least 2 to 5 per cent of the total population in many refugee situations. Experience worldwide shows that the vast majority of ‘unaccompanied’ children have living parents or other relatives willing and able to care for the child, and that these relatives can be located through well-organized tracing activities. Tracing often requires an extended period of time; and in the interim, unaccompanied children urgently require appropriate care and protection (See Panels 1 and 2 for details about unaccompanied children).

Supporting strategic objectives include:

• ensuring widespread dissemination of clear policies for unaccompanied children;

• identifying and mobilizing trained professionals (i.e. social workers specialised on child welfare) within the population and, if necessary, from elsewhere in the country, to define needs and establish appropriate programmes;

Basic Principles

The CRC provides the guiding principles for UNICEF’s support to unaccompanied children. In case of refugee children, the provisions of the 1951 Refugee Convention and the 1967 Protocol also apply. Some of the most important CRC provisions with respect to unaccompanied children are the following:

Article 3: (1) “In all actions concerning the child, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.”

Article 7: (1) “The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.”

Article 8: (1) “States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.”

Article 9: (1) “States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child.”

Article 20: (1) A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State. (2) States Parties shall in accordance with their national laws ensure alternative care for such a child. (3) Such care could include, inter alia, foster placement, kafala of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child’s upbringing and to the child’s ethnic, religious, cultural and linguistic background.

Article 22: (1) “States Parties shall take all appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee... receives appropriate protection and humanitarian assistance... (2) For this purpose, States Parties shall provide, as they consider appropriate, cooperation in any efforts by the United Nations and other competent intergovernmental organizations or non–governmental organizations cooperating with the United Nations to protect and assist such a child and to trace the parents or other members of the family of any refugee child in order to obtain information necessary for reunification with his or her family. In cases where no parents or other members of the family can be found, the child shall be accorded the same protection as any other child permanently or temporarily deprived of his or her family environment for any reason...”
Other key guiding principles for working with unaccompanied children, explicit and implicit in the Convention, include the following.

**Protection**: All children, including those who are separated from their families and/or in countries other than their own, are entitled to protection of their personal security and rights under national and international law, to provision for their basic subsistence, and to care that is nurturing and appropriate to their age and individual needs.

**Participation**: Children of all ages, in keeping with their degree of mental and emotional maturity, have the right to express their views and have those views taken into account in decisions regarding arrangements for themselves and their younger siblings.

**Legal representation**: Unaccompanied children have a right to physical and legal protection, as their individual circumstances require. This includes legal representation and designation of guardians, where needed, and securing land rights when all immediate family members have died.

**Family unity**: All children have a right to a family, and families have a right and responsibility to care for their children. All reasonable measures are taken to help families stay together and to reunite families who become separated.

No action is taken which could encourage family separations or make family tracing and reunification more difficult.

**Reunification of separated families**: Unaccompanied children have a right to reunite with parents, guardians and extended family members. Those intervening on behalf of unaccompanied children have an obligation to assist them to find, communicate with and rejoin family members through tracing and other services. Family tracing is pursued as a priority for all children separated from their families. When tracing is successful, an assessment is undertaken to determine whether family reunion is in the best interests of the child and, where appropriate, reunification is assisted and follow up assured.

**Delaying adoption**: Experience from various emergencies suggests that separated children should not be considered for adoption during an emergency or before extensive tracing efforts have been made without success – normally a period of at least two years.

**Field-Level Strategies and Actions**

Pending reunification, documentation and tracing activities should be integrated with community – and family–based arrangements for the care and protection of the child. An understanding of the historical, cultural, social and economic context is essential. This understanding includes the formal, informal and traditional structures as well as the coping mechanisms of the community. Interventions should build on traditional values and customary practices.

Once the immediate survival needs of unaccompanied children are met, resources should be focused on support for all children and on ensuring that unaccompanied children are fully integrated into the community. In addition to tracing and legal assistance, special programmes and services for unaccompanied children as such should be avoided, especially in acutely impoverished communities. In order to prevent further separations, programmes for unaccompanied children should always be linked with programmes to assist acutely distressed families.

Panel 3 illustrates the sequence of actions where there are large numbers of unaccompanied children. A two–to three–year period should be planned and budgeted for from the outset for tracing and family reunification, and for interim care arrangements. A dynamic, flexible social welfare approach is needed. Plans will need to be modified as the situation evolves. Potential donors must understand the need for a continuous commitment rather than for ‘relief’ activities and they should be involved in the planning process.

The following sections discuss in more detail the principal operational components of a programme for unaccompanied children.
Policies and standards

Clear policies and standards concerning unaccompanied children should be established and promoted as rapidly and as widely as possible. There is no universal blueprint. Arrangements will depend on the scale of the problem, the traditions of the society concerned, and the main causes for separation.

• Policy statements should define who is an unaccompanied child, provide the basic framework and standards for their care and protection, and set procedures for screening and verifying claims.

• Policies should be applicable to all government bodies, including the military, other non-state entities (e.g. rebel groups), international organizations and NGOs that may be in contact with children, and clearly assign responsibilities among these groups.

• It is often useful for UNICEF, UNHCR and the International Red Cross (ICRC and IFRC) to issue a joint statement. This should be done, if deemed appropriate, as soon as possible before any undesirable practices begin.

• Where communities have crossed national boundaries, regional (inter-country) approaches to assure shared and complementary definitions, documentation and strategies should be developed.

• All guidelines and forms must be printed and completed in the language of the affected population. Translations must be carefully checked and avoiding delays, translated back into the original language.

Identification and registration

Components of Programmes for Unaccompanied Children

- Policies and standards
- Identification and registration
- Tracing
- Interim care
- Family reunion and long-term placement

Children who appear to be unaccompanied should be identified, registered and medically screened as quickly as possible. Parents who have lost their children and are searching for them children should also be registered.

Searching for unaccompanied children

Searches and inquiries should be organized within each community in a way that does not disrupt existing care arrangements or encourage families to abandon children. Community social workers, volunteers, and community and religious leaders should be mobilized to do this throughout the acute phase of an emergency. Unaccompanied children are frequently found:

In or near hospitals, clinics, schools, churches, temples, mosques and food/relief distribution centres as well as pre-existing community welfare centres and orphanages. These are also places where families often seek shelter or services and can be screened. During population movements, children may be found along the routes taken. In urban areas, many may be roaming around as street children.

In conflict zones, aided by members of military units. Arrangements should be made with authorities to register and place these children under civilian care as quickly as possible. They should then be cared for in the same manner as all other children separated from their families.

If a census or registration of the entire population is being undertaken – e.g. in the case of a displaced population – unaccompanied children can be identified, without making any special separate inquiries. Questions should be asked in a way that does not encourage inappropriate separations.
Information/registration centres

**Screening and registration**

All children who appear to be ‘unaccompanied’ must be immediately screened to determine whether:

- they are indeed separated from their families;
- there is another adult with whom the child has been living who, with some support (e.g. assured food rations), could continue providing appropriate care;
- they are without the possibility of such continued care and must be placed in emergency care.

Information/registration centres should be established or designated. They should be easily accessible so parents who have lost children can register; communities can report unaccompanied children for whom they are caring; young unaccompanied children can be brought by people who find them but are unable to care for them; and unaccompanied children can present themselves.

As much as possible, existing locations or institutions where people traditionally go for help should be used. The establishment of offices specifically for unaccompanied children should be avoided. The locations of these information/registration centres should be widely publicized. Where there appears to be an adult who could provide care, the child and adult should be interviewed separately and a home visit carried out as soon as possible to assess the relationship. A small amount of food may be provided pending the assessment.

For each child who cannot be immediately reunited with parents or members of his/her extended family, immediate action should be taken.

**Register the child with a unique reference number:** The register should establish an individual file including as a minimum a name and the present location of the child, and who is caring for him or her.

**Document all information available:** This should come not only from the child but also from accompanying adults, including exactly where and when the child was found. This is especially important for infants and very young children. Standard registration and social history forms should be used.

**Provide each child with an identity bracelet or card:** This should preferably have a photograph attached.

**Arrange a health check and psychological screening:** Health and social workers can use simple techniques when professional services are lacking or delayed.

**Assessment and documentation**

Each child should be assessed to determine his/her particular needs, taking account of age, physical and mental health, personality, and social and cultural background. It is important to take into account the particular conditions the child has experienced in the recent past, e.g. reason for separation, witnessing or being a victim of violence, etc. Trained professionals should assess children. During the initial stages these can be social workers, health−care workers or other community workers. All information necessary for tracing and care should be systematically documented.

Standard forms for registration and the compilation of social history information are provided in Further Guidance. These should be adapted for each situation. Panel 4 lists the categories of basic information to be recorded for each unaccompanied child. Note that:

- In some situations of intercommunal strife, recording a child’s ethnic group or religion may put the child at risk, and these details should be omitted from the registration form and all other documentation.
- Copies of all documented information should be readily available to the persons caring for the child, as well as the central registration and tracing unit (normally managed by ICRO).
• Arrangements must be made to record different versions – different spellings and/or structures – of names and addresses, as well as aliases by which a child or adult may be known. (The computer programme used to help match names and addresses given by children with those given by parents has to include routines to check for such different versions.)

Interviewing children

Parents searching for Children

Parents who have lost children should provide information on:

• personal details of the children;
• family structure;
• circumstances of the family/child separation;
• history of the child before separation;
• medical history of the child;
• the family’s intentions, wishes and plans;
• other information relevant to tracing.

Families must then inform the registration/information centre if they change location.

During the initial interview, it is particularly important to gather and record as much information as possible concerning:

• where the child spent the previous night;
• any previous locations the child stayed in;
• how long ago and in what circumstances the child became separated from his/her family;
• when and where the child was found;
• the names of missing family members.

Despite the pressure of time and circumstances, the process of collecting accurate, factual information from a child must be done with great care and at a pace set by the child. A series of short sessions may be best, especially for a child who has had particularly traumatic experiences. Indirect rather than direct questioning is often more fruitful with young children. Children must never be pushed faster or further than they wish at a particular session. They must not be ‘interrogated’.

Interviewers should:

• be carefully selected personnel from the child’s own community;
• have prior experience in working with children, and be trained not only in interviewing techniques but also in gaining information from observations and by non-verbal means;
• be introduced to the child by someone the child already knows and trusts. (The child and caregiver should be fully informed of the purpose.);
• be responsible for protecting a child’s right to confidentiality (approaches must be adapted to the age and maturity of the child);
• share the same language and cultural background as the child (If this is impossible, interpreters must be trusted members of the child’s own community, considering not only language abilities but also maturity, impartiality, personality, relations with others, intelligence, patience and commitment.);
• develop an effective working partnership before starting to interview children.

Recording by Care-givers

Information on temporarily placed children should be recorded on an on-going basis, by caregivers, foster parents or staff in group homes or temporary emergency care centres. This should include clear, explicit
descriptions of the emotional state and behaviour of the child: e.g. “rarely talks to others”; “will not eat”. They should not use psychological terms such as “depressed”, “mentally retarded” to label a child.

Interviewers must give careful attention to:

- Timing of interviews in the morning or early afternoon, to allow the child time afterwards to play and otherwise cope with traumatic memories before going to bed.
- Concluding interviews on a positive note, and preferably in the company of an adult caregiver who will stay with the child afterwards.
- Recording their own opinion concerning the accuracy of the information.
- Describing the condition of the child when the interview occurred.

Tracing

Once a child has been identified as unaccompanied, both active and passive tracing efforts should begin immediately. In passive tracing, the records of children and of parents searching for lost children are compared to seek matches. Active tracing consists of proactive investigations to locate a child’s family based on all accumulated information about the identity of the child and the identity and location of family members. Speed is essential, especially for young children. The following should be considered in all tracing activities:

- All tracing activities should protect the personal security of the child and family members concerned.
- A central database should be established, normally by ICRC, to receive and store data on both children and parents who have lost children.
- ICRC and other organizations working with children at the local level should pursue ‘passive’ and ‘active’ tracing efforts simultaneously and cooperatively.
- All parties involved in providing care should exchange information and participate in coordinated efforts at local levels to trace families.
- All organizations should agree to common standards for verifying claims and assuring follow-up, and should keep ICRC (or any other central registry) informed using agreed standard forms and systems of notification.
- No action should be taken that may hinder eventual family reunion, such as adoption, change of name, or movement of a child far from the likely family locations.
- The child should be kept informed of efforts and progress but should not normally take any direct part in tracing.
- Tracing efforts may include children who are living with relatives (therefore not ‘unaccompanied’) but would benefit from organized tracing activities to locate lost parents.
- Even if both parents are dead, reunion with siblings, other adult relations or close friends may be possible.

Understanding the ‘close’ relationships and familial responsibility towards children within the local culture is essential: There are marked differences between matrilineal and patrilineal societies. Clan, tribe and caste may be important, and there may also be more than one adult with whom a child could be reunited.

Tracing techniques

In all tracing efforts:
• Information should be sought, without disclosing the child’s whereabouts;
• All claims for children should be subject to strict verification.

Methods that have been found to be useful in tracing children’s families include:

• posters with pictures and brief details about children displayed in public places where people congregate;
• tracing books containing copies of pictures and data sheets circulated by workers within the children’s original communities;
• tracing teams travelling to the child’s original community and making inquiries of local representatives and social institutions and in markets and other public places;
• announcements made on the radio, or in newspapers, about tracing activities in general and the names of the parents being sought.

Confidentiality and security

In some conflict and refugee situations, asking questions and circulating information may endanger the child or the family. In the sharing of information between organizations and the publication of information, including photographs of children, the basic principle should be, ‘Maximum information for tracing at the minimum risk to the child and family.’ When security is a concern, consideration may be given to circulating pictures with only an identifying number withholding names and present locations until any claimant’s identity and relationship to the child is verified.

Verification of identities and claims

Whenever adults claim children, or family members are traced, their identities and claims must be verified before the adults and child are brought together. Claims made are sometimes mistaken, or false and different families can claim the same child. In all cases, protection of the child’s best interests must be the overriding concern. Exchanging photographs, comparing descriptions of people and home surroundings, and cross-checking knowledge and accounts of events and family composition help to verify claims.

First meetings of parents and children

Children can be taken to locations they have described – possibly after arranging to meet there with parents who have reported losing children. This can be traumatic for the child if the parties are not properly prepared for the first meeting or the process of mediation and reunification. An alternative is to allow parents to make supervised visits to places where unaccompanied children are living or attending school, without meeting the children immediately.

Intercountry coordination for refugee children

In cases of refugee children, tracing activities must be closely coordinated between the country of asylum and the country of origin. Arrangements must also be made for the reunification of children with families found in the other country, and for the continuation of care and tracing for children returning to their country of origin as part of a voluntary repatriation programme. This requires close cooperation and joint planning between the governments, UNHCR, UNICEF, ICRC, and implementing agencies in both countries.
Considerations for Interim Care

Pending family reunion or alternative long-term placement, care for unaccompanied children should be arranged in a family or family-like environment of the child’s own community. If that is not possible, group care arrangements should try to replicate a family environment normal to the culture. The goal is to provide an environment that meets the physical, psychological, emotional and developmental needs of the child (see Panel 5 for Possibilities and Preferences). Special attention must be given to the care of unaccompanied infants. Key considerations for interim care include the following.

Community responsibility: Communities and local authorities should have the primary responsibility for assuring the protection and family-based care of unaccompanied children, and facilitating family reunification. Community-based welfare associations, women’s groups, and the local Red Cross/Red Crescent should be involved as much as possible.

To ensure cultural, linguistic and social continuity of care, unaccompanied children should:

- be cared for by persons from their own community or at least from the same ethnic and social background in order to ensure cultural and linguistic continuity;
- attend school;
- be encouraged to join in social and recreational activities with other children in the community;
- continue their religious practices.

Involvement in/commitment to tracing and family reunification: The families, communities and organizations involved in assuring interim care for unaccompanied children should also be involved in and committed to tracing and family reunification activities.

Maintain sibling and surrogate family groups: Sibling groups should be kept together. Where children have been living together as a group and have developed close emotional bonds, it is usually in the best interests of the children to preserve such groupings – provided there is no abuse of younger children by older ones – while at the same time establishing a substitute parent relationship.

Support to families caring for children: Families caring for children other than their own should be supported. They should be helped to secure health and other basic services and any relief entitlements available to all families with children. If, during an initial phase, there are inadequacies in the general food distribution system, they may receive small quantities of extra food or other support. No financial or other material gain should be attached to the fostering of an unaccompanied child, as this could affect the motives of potential caregivers and not be in the children’s best interests.

Institutional care only as a last resort: Large centres with special facilities almost always fail to meet children’s emotional needs. Worse, they attract the placement there, of children who are not in fact unaccompanied, thus splitting families. Once ‘institutionalized’, children often find it hard to integrate back into family and community life. Children in institutions should be moved into family-based care as soon as possible and the centres/institutions phased out as quickly as possible. Where there is no such existing option, one should be organized from the outset to replicate normal family care in the children’s own culture as much as possible, with surrogate parents who live with and are responsible for each small group of children.

Group Care Centres or Homes should:

- be limited to five to eight children of mixed ages and sexes;
- have facilities similar to those of a typical household in the community;
- have ‘house parents’ selected from the local community;
- be integrated into the local community as much as possible

Community integration: Unaccompanied children in all types of care should attend the same schools and use the same health services as other children, live in the same type of houses, eat the same food, wear the
same type of clothes.

Deliberate efforts must be made to minimize perceptions that unaccompanied children are privileged in relation to other children in the community, otherwise parents and guardians may be encouraged to abandon, temporarily or permanently, their children into such special care (see Panel 6). Efforts must also be made to minimize the opposite, that unaccompanied children are inferior, encouraging segregation and discrimination.

Registering/monitoring/supervising placements: All placements should be properly documented and formally registered so that children’s locations are known at all times. Where possible, trained social workers should monitor and supervise all placements on a regular basis to help and advise both the child and the foster family, or house parents, and to ensure the child’s safety and best interests. Workers ideally should make both regular and unannounced visits to observe relationships and to talk with the child (separately from the family), the caregivers, neighbours, and teachers. Wherever possible, a community committee should monitor overall arrangements and individual placements, in collaboration with assisting organizations (See Panel 7).

Move children only when absolutely necessary: Stability and continuity in care should be assured as much as possible. Six months should be considered the minimum commitment for all involved. For those in close contact with children – members of the child’s own community – a longer commitment is desirable. Children should not be moved between locations or different care arrangements any more than absolutely necessary for their safety and well-being. Whenever movement is necessary:

- the child must be prepared beforehand;
- all movements recorded, allowing tracing of the child’s location at all times;
- all concerned parties must be informed, including the central focal point for tracing (normally the ICRC);
- all pertinent documentation concerning the needs of and what is known about the child must accompany the child; and
- formal agreements should be established with those taking custody of the children and all other parties concerned to assure that appropriate care and protection will be provided and that family reunion will be expedited.

Arrangements for Interim Care

Spontaneous care arrangements

A child being cared for by an adult who is not a relative should normally stay with that adult, or family, at least temporarily, if the relationship is a benevolent one and the child’s needs are being met.

The child and the care arrangement should be registered and the quality of care assessed by a community–based social worker as soon as possible. This should be done carefully so as not to disrupt the relationships or encourage the care–giver to abandon or hide the children. Where satisfactory, the arrangement should be monitored and the family supported as any other foster family. If it is suspected that the child is being abused, neglected or exploited (e.g. being used as a domestic servant), the situation must be quickly assessed and, if necessary, an alternative placement arranged immediately.

Supervised foster care

Children, and especially infants and young children, who are without adult care should immediately be placed in family care whenever possible.
Respected community leaders and child care workers should identify and interview families. Some criteria are suggested in Panel 8.

Foster families should agree to care for the children without the promise of compensation. They should provide the same commitment to care that their own biological children would have.

Each placement with approved adults/families should be registered. This should include a signed agreement including the above conditions.

Group care in small, community−based homes

Where family−based care cannot be immediately organized or is not advisable, small group care is strongly preferable to institutional care – it can replicate more closely normal family care in the children’s own culture.

Group care centres should be organized through community leaders and/or local organisations in cooperation with child−care workers. The community should assume the responsibility for the children, who should attend normal community health services, schools and recreation activities. Documentation and tracing efforts should continue.

A normal age spread is desirable within each surrogate family group. Those who are older should be separated by gender for sleeping. Infants below one year should be cared for on a one−to−one basis by a surrogate mother and can live as part of a small group with other caregivers and children. When children one to four years of age are placed together, they should ideally have one care provider for every three children.

Continuity of relationships should be assured and an environment as close as possible to a “normal” home and family be created. Children should be able to move within the community and mix with other children.

House−parents should be adults that meet these conditions: adults who speak the children’s own language. They should have reared their own children or have experience in child health or welfare services. They must be willing to continue in the job for the foreseeable future. They should receive relevant training and instructions, and ongoing support from community−based child care workers who also supervise the operation of and relationships within the units. ‘House−parents’ may be remunerated in a manner similar to other community service workers.

Assistants may be chosen from among unaccompanied adolescents who need a secure place to live. Other young people may help provide care for younger children and facilitate their integration into the life of the community.

Material provisions for the children should be similar to those for other children in the community. They should attend the community school and participate in the normal recreational and other activities of children in the community.

Temporary emergency care

Arrangements for Adolescents

Family vs. group living: Placement with a family remains the best option for many adolescents. Others may be integrated into group care, but some may be opposed to any such arrangements. Living together in independent small groups, with adult supervision, may best support their coping strategies.

Preparing for adult living: Arrangements must be designed to prepare adolescents for adult living while
ensuring ongoing adult supervision, assistance and support. Adolescents need long-term emotional support from role models within their own community, and training to become self-sufficient within the community.

Training opportunities: Vocational training or, better yet, apprenticeships should be arranged based on compatibility with the adult willing to share professional experience and skills of interest with the adolescent.

The immediate fostering of all children without adult care may not always be possible, and it may take time to organize small group homes. This may be the case when a displaced population is not yet geographically stable, or the society rejects caring for children who are not of their family, clan, etc., or when all households are in acute distress. As a last resort, shelter, food and water must be provided in temporary emergency care centres under the supervision of trained child-care workers.

**The time spent in emergency care centres should be minimum.** Stays should be only what’s necessary to arrange family reunion or more appropriate placements – a few days at most.

**Temporary emergency care centres should normally be located within, not outside, the main community.** This is to facilitate tracing activities and integration of the children in their communities. They may be associated with – be at or close to – the designated centres where people will come for information about missing children.

**Emergency care centres should be phased out as soon as all children can be placed in more appropriate interim care.** A target date should be set for closing down such centres.

**The resources invested in such centres should not affect resources invested in efforts to ‘normalize’ the situation.** Investments should instead be directed to support tracing activities, promote appropriate care, and provide services to acutely distressed families and to children to prevent family separations.

**Functioning centres should provide basic services.** These include shelter, water, food, physical security and care. Standards are given in Panel 9.

**Medical care, recreational and educational activities, and care to meet special needs should be planned.** These should be in the same context of services to meet the needs of all children in the community. Separate provision should be made for unaccompanied children only in extreme cases – e.g. where large numbers of very sick unaccompanied children have to be cared for during an initial, acute emergency phase – and then only on a temporary, short-term basis.

**Family reunion and alternative long-term placements**

When tracing is successful, it should determine whether family reunion is in the best interests of the child. Panel 10 lists the main considerations about family reunification or alternative long-term care arrangements. Reunification should be assisted and followed up. Alternative long-term arrangements should be made when family reunion proves not to be possible within a reasonable period, or when reunion would not be on the child’s best interest.

**Each case must be considered individually in the context of child welfare policy, legislation and cultural practice in the country concerned.** However, children – especially infants and young children – should not be kept ‘in limbo’ for periods of years in the vague hope that family reunion may eventually prove possible.

In countries where adoption is recognized and/or allowed, it should only be carried out in the best interests of the child, and then only with the authorization of the competent national authorities and with safeguards for the child (as required by the *Convention on the Rights of the Child*, Article 21).

**Reunification programmes should be carried out within the legal framework of the country.** Otherwise organizations could end up acting as independent foster care services making essentially legal decisions about the placement of children.

**The success of the reintegration is largely dependent on the cause of separation.** Difficulties often arise when the separation had been voluntary, usually requiring follow-up and continuing support to the family. Other problems are often related to the economic circumstances of the family, the length of separation, and the nature of the kin relationships.
Assessment for family reunion

Once identities and relationships have been confirmed, the child and the relatives should be counselled separately and prepared for meeting and eventual reunification. It is important to do the following:

**Inform the parents/relatives about the state of the child:** Ascertain whether they are both willing and able to look after the child (until he/she reaches adulthood).

**Inform the child about the circumstances and wishes of their parents/relatives.** Establish the child’s feelings about them – to determine whether the child is willing to live with them, only to establish contact, or neither.

**Investigate carefully any accounts of previous abuse or neglect of the child:** This should include parents, relatives or other community members.

**Ensure that all parties are ready to be reunified:** The circumstances of the separation may need to be discussed at length and issues arising from them resolved before reunification. Visits should normally be made to the home of the family.

If it is not safe or possible to reunite the child with his or her family immediately, inform the child of the situation and the reasons, and maintain contacts between the child and the family. The ICRC’s family message service may be used.

Preparation for and follow up to reunification

**Reunification with Families**

It is important to:

- provide counselling to allay any fears on the part of the child;
- carefully plan arrangements for transport and actual meeting;
- assure ongoing counselling to the family, where required, and access to necessary community services and assistance.

If the child is to be reunited with his/her family after a long separation, the process of re-establishing relationships must be carefully planned and nurtured.

Particularly where the separation has been for more than a few weeks, or when either the child or other family members have been seriously traumatized, there is need for periodic monitoring to ensure the child is receiving appropriate care.

Assistance and counselling through general community-based programmes will be particularly important if the child is handicapped, the family weakened, or the community as a whole impoverished.

**Alternative long-term placements**

Where family reunion is impossible or not in the child’s best interests, permanent integration (in keeping with and legitimized by local law or custom) into families within their own communities is preferred, especially for young children. Ideally, this would be with the families who have cared for them on an interim basis.

Supervision may be needed for an extended period and arrangements made for support available to all families and children through general community assistance programmes.

It may be necessary, especially for older children, to maintain small group homes or supervised living arrangements, and to make special efforts to provide children with training for employment, formal and non-formal education and recreational activities within the community.
Placement in large institutions must be avoided. They do not meet many of the children’s development needs and are often very expensive and very difficult to maintain long-term.

**Coordination and Partnerships**

Coordination and communication between all organizations and authorities concerned with and working on behalf of unaccompanied children is essential. Mechanisms for discussion, information sharing and coordination must be established from the earliest possible moment, normally under the auspices of the government body/department responsible for child welfare. Coordination may be facilitated by a declaration of intent or memorandum of understanding at the start of an emergency.

Primary responsibility for the coordination of programmes at central and local levels lies with the government.

Operational functions should be delegated to specific agencies working under the overall authority and supervision of the national child welfare authorities, with one agency (usually ICRC) designated as the focal point/coordinator for tracing information.

National child welfare services or other relevant local authorities should normally provide an overall framework for coordination of action on behalf of unaccompanied children. A special unit may be needed within the national child welfare service to oversee any large-scale programme. Technical assistance and material support should be provided to that unit, if needed.

**Inter-country Adoption**

In order to preserve his or her own identity and culture, inter-country adoption should be considered only if:

> “the child cannot be placed in a foster or adoptive family or cannot in any suitable manner be cared for in the child’s country of origin” [CRC, Article 21.b].


**UNICEF** and **UNHCR** (in case of refugees) have a fundamental responsibility to assist governments to fulfill their responsibilities, including ensuring coordination. In circumstances where there is no authority in control, a competent organization should assume this role.

NGOs (including the national Red Cross/Crescent society) should be carefully selected and are often best suited to work at the community level, organizing care, tracing children locally and reuniting families.

- Any organization from outside the community must have demonstrated professional competence in child care and the management of the particular services needed.
- Any organization involved in arranging care for unaccompanied children must be in agreement and act in accordance with the established policies and principles. It should not have any conflicting objectives, such as international adoption, resettlement or religious conversion.
- Any community-based organization, especially women’s groups, should take maximum responsibility for the programme (and eventually assume full responsibility). Youth should be mobilized to help. NGOs from outside the community should support the community groups concerned and, at the same time, maintain close and continuous links with the local government administration, and health, education and other social services and programmes in the locality.

**Further Guidance**


Refugee Children: Guidelines for protection and care, UNHCR, 1994


Working with Unaccompanied Minors in the Community – A family-based approach, UNHCR, 1994 [includes detailed guidelines on interviewing and documentation]

Panels

Panel 1 – Definition of an ‘Unaccompanied’ Child

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<thead>
<tr>
<th>DEFINITION OF AN ‘UNACCOMPANIED’ CHILD</th>
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<tr>
<td>The term ‘unaccompanied child’ refers to:</td>
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<td>A child who is under 18 years of age or the legal age of majority, as defined by the Convention on the Rights of the Child (CRC), is separated from both parents and is not being cared for by a guardian or another adult who is responsible to do so by law or custom.</td>
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This definition includes the following.

- Children who are without any adult care, by themselves or with siblings;
- Children who are with families other than their own;
- Children who are with relatives who are unknown to them, have no customary responsibility for them, and are unable or unwilling to care for them on an ongoing, long-term basis.

*Note: Most children who are separated from their families are not orphans and should not be referred to as such. It is important that a local-language term, or phrase, be found and used that conveys the sense of ‘children separated from their families’. Some authorities and other documents use the term ‘unaccompanied minor’ or refer to ‘unaccompanied children and adolescents’.*

Panel 2 – Reasons for Children Becoming ‘Unaccompanied’

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<tr>
<th>REASONS FOR CHILDREN BECOMING ‘UNACCOMPANIED’</th>
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<tr>
<td>Before, during and after an emergency, a child may become separated from his/her family or adult next-of-kin in various ways. Understanding of the reason(s) for separation is essential to guide actions taken on behalf of unaccompanied children, both individually and collectively.</td>
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Against parents’ will, a child may be:

- **Lost**: Accidentally separated from other family members.
- **Abducted**: Deliberately taken away from parents by other adults, authorities or organizations.
**Recruited:** Enlisted in fighting units with or without their parents’ consent, or their own. They may also be left alone when parents, or guardians, have been abducted or imprisoned.

- **Runaway:** The child has chosen to leave and live apart from his or her parents without their consent.

- **Orphaned:** Both parents (or legal guardian) and all close adult relatives in ‘extended’ families are dead.

**With parents’ consent, a child may be:**

- **Abandoned:** Deserted by parents who have no intention of subsequent reunion (this can include ‘unwanted’ babies).

- **Entrusted:** Placed voluntarily in the care of another adult, or institution, by parents who intend to reclaim him/her eventually.

- **Independent:** Living apart from parents (alone or with others) by mutual agreement.

- **Rejected:** The child is ‘forced’ by the parent(s) to leave home. Children may become unaccompanied as a result of family breakdowns and rejection by a parent’s new partner, pregnancy, school dropout, etc.

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**Panel 3 – Programme Actions Required for the Care and Protection of Unaccompanied Children in Emergencies**

Programme actions required for the care and protection of unaccompanied children in emergencies

**Panel 4 – Basic Information Required for the Documentation of an Unaccompanied Child**

**BASIC INFORMATION REQUIRED FOR THE DOCUMENTATION OF AN UNACCOMPANIED CHILD**

Basic personal data:

- family name, forename, given names, nicknames, or other names
- sex
- date, place and year of birth
- tribe, caste, ethnic origin, nationality
• languages spoken, religion, education
• particular identifying features (disabilities, scars, etc.)
• personal belongings

Accompanying siblings (brother/sisters/other child relatives):
• same as above
• address, if different from the child

Circumstances when identified:
• location/address where found
• date and time

Accompanying adult (not–related):
• adults’ names, addresses, relationship to child (if any)
• if in care of these adults, how the association came about
• the length of time the child has been with them
• if with other unaccompanied children, the names and reference/ registration numbers of the other children, how long they have been together

Family relationships:
• name, age/date of birth, relationship to child, occupation of family members
• last known location/address of father, mother, brothers, sisters, grandparents, aunts, uncles, other relatives, other persons normally living in the family household

Circumstances of the family/child separation:
• reasons for date and place of separation
• when and in what circumstances child last saw parents/other family members
• if death of parents is presumed, reasons why child believes this to be so

History of the child before separation:
• important events in the child’s life
• description of people and places remembered

History of the child since separation:
• places of residence
• legal status of any formal placements, length of time spent in each place, important events, people and places remembered
• how shelter, food and water have been obtained

Health status and past medical history

Psychosocial assessment:
• appraisal of the child’s current emotional state
• the importance of current relationships
• extent to which the child’s (age–specific) developmental needs are being met
• other information of importance for the daily care of the child

The child’s intentions, wishes, plans:
• with whom the child wishes to be reunited if they could be located, their relationship, where and how they might be traced
Other information relevant for tracing:

Names and locations/addresses of other persons who may provide additional information that might be helpful in establishing the child’s identity, locating family members or understanding more fully the circumstances of the separation. Information relevant to the determination of refugee status and wishes for repatriation or resettlement, where appropriate. (This is defined and its collection assured by UNHCR.)

Panel 5 – Possibilities and Preferences for the Interim Care of Unaccompanied Children

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<thead>
<tr>
<th>POSSIBILITY AND PREFERENCES FOR THE INTERIM CARE OF UNACCOMPANIED CHILDREN</th>
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<tbody>
<tr>
<td><strong>For all infants and young children (0–5 years):</strong></td>
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<td>• Family care (fostering) with adult relatives;</td>
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<td>• Family care with the families of friends; or</td>
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<td>• Family care with other families in their own community.</td>
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<td><strong>For older children (6–14 years):</strong></td>
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<tr>
<td>• Family care, as above, for as many as possible; or</td>
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<tr>
<td>• Group care in surrogate family groups in community−level homes, for any for whom family care is not immediately possible.</td>
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<tr>
<td><strong>For adolescents (over 14 years):</strong></td>
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<tr>
<td>• Family care;</td>
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<tr>
<td>• Group care; or</td>
</tr>
<tr>
<td>• Supervised independent living (in small groups).</td>
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<tr>
<td>For infants and younger children, one−to−one care or family placement is critical to their well−being. Infants need a surrogate mother.</td>
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<tr>
<td>For older children and adolescents, their individual needs and preferences should be determining factors.</td>
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<td>For sibling groups, make arrangements in consultation with the oldest child to keep them together (with the same foster family or in a group home), or at least for the older children (possibly living independently) to remain in close contact with the younger ones (in a foster family).</td>
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Panel 6 – Questions Concerning Community Traditions and Capacities

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<tr>
<th>QUESTIONS CONCERNING COMMUNITY TRADITIONS AND CAPACITIES</th>
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<td>• Which adults would normally care for children separated from their parents? What are the traditional methods of caring for children separated from their families or guardians?</td>
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<td>• If these traditional patterns have been disrupted or are overwhelmed, what arrangements do the community and religious leaders, educators, social workers and concerned local groups propose for such children?</td>
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<td>• What existing structures and mechanisms can be used as focal points to receive information on and register children separated from their families?</td>
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<td>• How can the community carry out a plan to locate children separated from their families?</td>
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<tr>
<td>• Are concerned adults already caring for children who are not of their own family? If so, can such care be maintained?</td>
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<tr>
<td>• Are there other adults/families who would be willing to provide care for (to ‘foster’) one or more unaccompanied children, at least on an interim basis?</td>
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<tr>
<td>• Are there other adults who would be willing to serve as surrogate parents (‘house parents’) for small groups of unaccompanied children living in the community?</td>
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</tbody>
</table>
• Are there any trained child welfare workers, or other social workers, in the community available to help organize and supervise the screening, assessment and care of unaccompanied children, and tracing activities?

• Are there any local groups (NGOs, women’s groups, religious, etc.) willing to become partners in caring, tracing, reunifying children?

Panel 7 – The Care of Children in Foster/Family Care

THE CARE OF CHILDREN IN FOSTER/FAMILY CARE

• Weight gain is satisfactory according to monthly weight (or weight–for–height) measurements and visual observation.

• There are no signs of neglect, such as dirtiness, skin infections or inadequate clothing – checks on health and cleanliness, preferably weekly.

• There is good ‘bonding’ between child and the caregiver: they appear to be relaxed with each other and there are indications that the child’s emotional needs are being met.

• The child is not treated differently from other children in the family: he/she does the same amount of work, attends school with the others and eats with them.

• Appropriate action is taken by the caregivers to meet the child’s needs: he/she is taken to a health worker when sick, attends school daily, is fed adequately, etc.

• The situation of the foster family is stable.

• The family is receiving the assistance to which it is entitled and support from appropriate services to meet the needs of the family (including the child/ren taken in).

Panel 8 – Criteria for Adults to Foster or Care for Children

CRITERIA FOR ADULTS TO FOSTER OR CARE FOR CHILDREN

Adults wishing to foster, or care for children should meet the following criteria:

- physical and mental health;
- a knowledge of the needs of children and how to meet them appropriately;
- a desire to foster/provide care for children for reasons that are not connected to personal gain;
- satisfactory living conditions in relation to standards in the surrounding community;
- a liking for children and the ability to offer them love and security;
- an understanding of the difference between fostering and adoption and a willingness to return the child to his/her original family if found.

A visit should be made to assess the home conditions and to check that every member of the family is agreeable to fostering. A verbal character reference should be sought from neighbours and local community leaders.

Panel 9 – Standards for Temporary Emergency Care

STANDARDS FOR TEMPORARY EMERGENCY CARE

Emergency care centres should be avoided wherever possible and, where they exist, should be closed down as quickly as possible. Where there is no alternative and for as long as such centres exist, the
following minimum standards should be maintained:

Security

• A safe and secure site; guards may be required.

• Each child in the care of a specific, responsible adult care provider who monitors the child’s whereabouts as well as well-being.

Water

• A reliable supply of clean water: at least 20 litres per child per day (an absolute minimum of 5 from day 1).

• Covered storage for at least one day’s needs, and adequate drainage from all water use areas.

Environmental sanitation

• Latrines or other arrangements for the sanitary disposal of faeces that are well away from water sources, cooking and eating areas.

• Latrines that are suitable for use by young children including at night, and are maintained at least once a day.

• Latrines allowing for gender separation (at least for older children and adults).

• Washing facilities and adequate cleaning materials.

Food and food preparation

• Assured supplies of appropriate food items similar to those available to other families, plus kitchen utensils and cooking stove.

• Items for rehabilitation of severely malnourished if they are to be cared for on-site (may/should be cared for in therapeutic feeding centres established for the community in general).

Health care and medical services

• Regular – preferably daily – visits by health workers able to assess health and nutritional status and provide vaccination and other primary health care services.

• Where there are large numbers of sick or severely debilitated children, separate rooms/tents for those children and full-time medical/nursing staff.

• Procedures for referral of severely ill children to community hospitals (including arranging transport).

Staffing

• Infants below 12 months: wet nurse/surrogate mother for each infant, and night care.

• Children 1–4 years: one care–taker for every three children.

• Children five years and above: one care–taker for every 8–10 children.

• Careful selection, training and supervision of all staff.

Management
Panel 10 – Decisions Concerning the Long-Term Care of Unaccompanied Children

DECISIONS CONCERNING THE LONG-TERM CARE OF UNACCOMPANIED CHILDREN

Within the framework of statutory or customary law, decisions concerning family reunification (when family members have been identified) or alternative long-term care arrangements are taken on a case-by-case basis by trained child welfare personnel, taking account of:

- the reason for the separation;
- the wishes and rights of the parents;
- the rights, wishes and age of the child;
- the length of separation (especially in the case of infants and very young children);
- the strength of the child’s new psychological attachments, notably to present caregivers;
- the wishes of the present caregivers (foster parents);
- the previous family-child relationship.

The safety and well-being of the child is always the overriding concern. However, decisions are not always easy – children and adults may not agree on what is in the child’s best interests.

Chapter 4 – Annex 1: Identification Photographs in Family Tracing

I.D. PHOTOGRAPHS CANNOT BE USED FOR OTHER PURPOSES WITHOUT A SPECIAL RELEASE

Most UNICEF photographs – for which appropriate copyright reproduction rights have been obtained – are documentary depictions of people in real situations. As such, UNICEF, assuming this depiction does not falsify the real identity and situation of the people depicted, or use the image in a context that implies a different reality, can freely reproduce them. This is both a legal and ethical issue. Photographs of people that are used in commercial or other situations that impose an interpretation different from reality require model releases, which confirm that the person depicted has consented to this use.

However, identification photographs taken of unaccompanied children in emergency situations are not documentary or photojournalistic depictions and therefore require model releases for advocacy or fund-raising uses by UNICEF. While journalistic coverage of a family tracing programme, including the taking of identification photographs, is a documentary coverage, the actual identification photograph is part of a programme and not a journalistic depiction of a child. As such, it requires a model release for use other than identification. This is a right-to-privacy issue in the same way as corporations and public institutions can only use identification photographs they have of their employees or clients for that purpose.

Following intense media interest in the 1994/5 joint ICRC/UNICEF family tracing programme for unaccompanied Rwandan refugee children, exhibitions using the identification photographs were only permitted after a joint agreement by ICRC and UNICEF (as the temporary guardians of the children in the absence of their parental guardians) to permit this limited advocacy use to raise awareness about the plight of these children. In addition to the privacy issue, it is important to bear in mind that family tracing identification photographs are part of confidential programmes. While the photograph is usually taken for wide dissemination aimed at reuniting the child with his/her parents/guardians, security situations may require these photographs to be kept confidential.

Chapter 5 – Internally Displaced Children and Women
Rationale

Internal displacement is one of the critical humanitarian issues of our time. An estimated 30 million human beings, 80 per cent of them children or women, have been forced to flee their homes and communities because of armed conflict, violence, systematic violations of human rights, or natural or man-made disasters. In keeping with its commitment to the most disadvantaged children, UNICEF must sharpen its focus on one of the least visible, most vulnerable child populations: the internally displaced.

The internally displaced, because of their extreme vulnerability, associated with separation from support systems, often suffer acutely. Without the structure and nurturing environments of their home communities, they are more vulnerable to arbitrary action by those claiming authority, more liable to suffer forced conscription or sexual abuse, more regularly deprived of food, water, health care and other essentials.

The internally displaced exist in a legal limbo and are often relatively invisible. Though they remain under the jurisdiction of their own government, conditions of displacement may affect that government’s ability or willingness to provide basic protection and services, as well as to facilitate access. The displaced may be concentrated in camps or large groups. They may need to locate in urban perimeter housing, with relatives, scattered within the general population, or in hiding, further diminishing visibility and access.

Who are internally displaced persons?

“persons or groups of persons who have been forced to flee their homes of habitual residence, in particular as a result of or in order to avoid the effects of armed conflicts, situations of generalized violence, violations of human rights or natural or man-made disasters; and who have not crossed an internationally recognized state border.”

According to the definition offered in “Guiding Principles on Internal Displacement”, (Office for the Coordination of Humanitarian Affairs, OCHA, February 2000)

An estimated half of all internally displaced persons (IDPs) are children who have been uprooted during a particularly vulnerable period of their lives. Surveys indicate that mortality rates among IDPs can be as much as 60 percent higher than rates for others in the same conflict-affected country. Conditions of displacement put at high risk the entire range of rights guaranteed children by the Convention on the Rights of the Child (CRC), including survival, protection and development without discrimination. Sudden and violent onset of displacement, by shredding family and community networks, can deeply disrupt the psychosocial well-being of children.

In addition to difficulties faced by all displaced children, subgroups may confront especially traumatic conditions. These include unaccompanied minors, ‘child soldiers’, sexually abused children, children who have witnessed great trauma, and children who suffer disabilities. Displacement increases children’s vulnerability long-term, increasing the risk of poverty resulting from loss of land, inheritance or other legal rights; incarceration or discrimination; inability to resume schooling; and related problems.

The international response on behalf of the internally displaced has historically been fragmented, conceptually disjointed and inadequate. Although the number of internally displaced far exceeds the numbers of refugees worldwide, unlike refugees, the displaced share no discrete legal regime, no lead agency with sole responsibility for their welfare, and no consistent, sustained donor funding pool.

In short, internally displaced children and their families present the world community, and UNICEF, with an exceptional crisis, the magnitude and severity of which demand a creative, focused response commensurate with the level of need.

General Aims and Strategies

Using the Convention on the Rights of the Child as its starting point, UNICEF’s policy is to ensure that children displaced under emergency conditions have the same rights to survival, protection and development without discrimination as other children.

UNICEF’s supporting strategies include the following.
Advocacy for IDP children: UNICEF takes a leadership role at the community, national and international levels to ensure that the special needs of displaced children are consistently brought to the attention of national leaders, international organizations, the media, donors, parties to the conflict, and other audiences through presentations, reports and other dissemination tools. Effective advocacy is built on accurate data collection, assessment, monitoring, and reporting.

Prevention activities: UNICEF designs, promotes and selectively implements activities that reduce the exposure of children to the risks of displacement. This is done by addressing the root causes of conflict, attempting to keep communities from becoming displaced, and attempting to maintain family and community cohesion during displacement. Creative attempts to support communities through advocacy efforts with authorities, deployment of security forces, presence of international staff, and strategic location of emergency services may prevent or at least diminish, wholesale displacement, with all its impacts on children.

Ensuring the survival of displaced children and women: UNICEF designs, promotes, and selectively implements programs designed to protect against malnutrition and disease during the dangerous and chaotic emergency phases of displacement. High death rates and morbidity often accompany unplanned, chaotic, large-scale displacement. Development of early warning indicators, prepositioning of supplies, and pre-crisis coordination with program and community partners are critical. Focused planning to track mobile displaced populations, prioritize needs and maintain logistics capacity are crucial to the survival of displaced children.

Protection of displaced children: Protection activities are among the most difficult and dangerous of interventions – whether carried out directly by UNICEF staff or organizations alerted by UNICEF to the special needs of displaced children. It is essential to protect IDP, children who are highly susceptible to violence, exploitation, abuse, rape, and recruitment into armed forces, to prevent long-term damage from displacement.

Rehabilitation and recovery: UNICEF supports displaced children, their families and communities through actions to restore psychosocial health, cultural activities, maternal and child health care, schools, water supply and sanitation systems, and self-supporting economic activities at the displacement site, beyond what is required for survival. Such activities to restore normalcy, planned with full community participation, provide the continuity that fosters the child’s normal physical, intellectual, psychological, cultural and social development.

Return to communities of origin: As soon as possible after life-threatening conditions are stabilized, UNICEF focuses on durable solutions to problems of internal displacement. Built on enhanced self-help capacity at the family and community levels, UNICEF assists in the mobilization of communities for resettlement, the transport phase, and preparation of the resettlement community for the return of IDPs. Resettlement programs are alert to issues of social reintegration, relations with persons not displaced, reconstruction of community infrastructure, and the need for long-term assistance to groups, such as children with psychosocial needs.

Basic Principles

Clearly, other important principles and considerations guiding UNICEF’s work in general apply to displacement emergencies as well. For example, UNICEF’s development orientation during emergency situations, its focus on country-specific analysis and its integrated approach to child well-being are important lenses through which to view displacement interventions. This chapter on IDPs builds on these broad principles, which are covered extensively in other UNICEF documents.

Three aspects of displacement impel UNICEF’s focused attention:

- displaced children are likely to be among the most at-risk of all children during emergencies, from food shortages, from disease, from assault;
- the process of displacement itself – with its disruption, insecurity and challenges to personal and community identity – puts at risk many of the rights guaranteed by the Convention on the Rights of the Child;
- displacement frequently results in other special needs of children.

Special analysis of circumstances of displaced children
In the absence of strong international institutional arrangements for the displaced, these children may become invisible, may simply ‘fall through the cracks’. Depending on other agency capacities, UNICEF may not take the program lead for displaced children on every occasion. But, with its central role as advocate for children, UNICEF must never fail to assess and understand the condition of displaced children, to ensure national and international focus on this especially vulnerable group.

Advocacy that confronts national sovereignty and responsibility

UNICEF’s mandate in emergency settings is clear: to generate a ‘first call for children’ by serving as an unflagging advocate for those children. Yet, internally displaced children, their families and communities are, by definition, within the boundaries of their nation and remain subject to the authority of the national government. In numerous displacement emergencies, national authorities have been incapable, or unwilling, to extend protection and care to IDPs. Such national authorities may welcome international efforts, remain neutral or oppose such efforts, especially when they extend beyond resources to protection activities. Jurisdictional issues are further complicated when displaced communities are part of an ethnic or religious group opposed to government policies or are located in territory controlled by a political movement in opposition to national authorities.

Creative programme design can bridge gaps, combining advocacy for the rights of the displaced with efforts to assist governments in meeting the needs of citizens.

UNICEF staff should, while keeping a clear focus on their primary responsibility to children, anticipate and plan for competing perspectives. The CRC, international humanitarian law, and other precedents provide useful bases for work on behalf of displaced children. The absence of a clear–cut legal regime for IDPs will ensure continued ambiguity in relations between international advocates and host governments. The forthcoming ‘Proposed Guiding Principles on Internal Displacement’ drafted by the Representative of the Secretary–General on IDPs, may further elucidate these relationships.

Certain programme efforts on behalf of IDPs may complement local capacity–building efforts or may strengthen relations with government authorities. In other cases, advocacy steps may generate official opposition. When difficult country–specific choices must be made, the best interests of children should serve as a clear guidepost.

Understanding the conditions of displacement

Though IDPs share key common characteristics – departure from their communities, extreme vulnerability, large percentage of children and women – they live in many diverse conditions. Identifying varying characteristics is critical in designing cost–effective responses to displacement.

Cause of displacement

Displaced persons may leave their homes for a range of reasons (conflict, natural disaster, economic impoverishment, environmental crisis, ethnic tension, political violence) that will affect children’s physical and psychosocial well being, their sense of community continuity, their adaptability to new surroundings, and their attitudes towards return and resettlement.

The Crisis ‘Timeline’

Displacement crises can be analysed in four stages, which drive certain programmatic responses. These are:

a. pre–emergency prevention and preparedness;
b. the onset of the emergency;
c. the ongoing crisis/early rehabilitation phase;
d. recovery and post–emergency.

For actions in each of these phases, see E/ICEF/1997/7, ‘Children and Women in Emergencies: Strategic Priorities and Operational Concerns for UNICEF’.

Type of displacement

- Mass crisis displacements are characterized by rapid, chaotic departure with abandonment of most resources, and a focus on escape rather than on a viable destination,
and evoke a response from the international community.

- **Multiple displacements** may follow, in which IDPs move, often on short notice, from one available sanctuary to another. Multiple displacement places extreme stress on children and requires particularly mobile and flexible responses from the international community.

- **Forcible displacement** where entire communities are moved for strategic or military purposes, may require representations to military commanders in order to access displaced children.

- **Static displacement** may find IDPs unable to return to their homes several years after departure but no longer in life-threatening situations. This situation requires careful analysis of the best interests of children, the relative value of resettlement or integration, and issues of cultural continuity.

**Location of displacement**

Locating displaced children, assessing their needs and advocating on their behalf depends on the location. Displaced children may be in camps, in urban perimeter housing, with relatives, scattered within the general population, with kinship groups, or in hiding. IDPs may make visits to their home communities for assessment or maintenance, potentially complicating protection services. Children may be sent to urban or rural areas, to relatives or to a different region of the country, based on the family’s assessment of safety, probability of recruitment into military forces or other factors. The attitude of local populations towards the displaced is a critical factor.

**Categories of needs**

Displaced children and their families may require a range of supports from UNICEF and partner organizations. IDPs may:

- need water, food, medicines, and other emergency services during the crisis phase of a displacement emergency;
- may require protection from groups attacking, exploiting or recruiting them;
- need advocacy support with government agencies or international organizations;
- require assistance in returning to home communities or alternative settlement if return is not feasible;
- need assistance in earning a livelihood during the period of displacement;
- confront unique problems if handicapped, girl children, child soldiers, children in single-parent households;
- face legal issues like land tenure disputes, either in the displacement site or in the home community.

A clear understanding of priority needs in the country setting, and of which interventions will contribute to durable solutions, is critical to shaping UNICEF’s program choices and resource allocations.

**Attention to Critical Gender Issues**

Two particular aspects of displacement – the breakdown of traditional societal norms and the increased likelihood of female–headed households – increase the risk of abuse for girls and for women, and the risk that programme benefits may not reach them equitably. Recognition of this in UNICEF programme design, advocacy and protection efforts, attempts at family reunification, and the provision of special accommodations are crucial.
Capacities of the Displaced

IDP capacity will vary according to factors like:

- community cohesion; the continued presence and acceptance of traditional community leaders;
- the degree to which families have remained intact;
- the ability to transfer economic skills to the displacement site; and, the degree of acceptance of the displaced by local residents.

Eliciting community views of strengths and weaknesses and maximizing these capacities are essential.

Two axioms are particularly compelling during displacement emergencies to ensure the survival and well-being of displaced children:

- the total contribution by the entire international community to the children's well-being is likely to pale compared to what families and communities will provide;
- family and community structures will be under great stress in emergencies.

The clear implication for UNICEF is that all advocacy and programme interventions should be designed to buttress families and community institutions. Recognition of family and community structures, eliciting their participation in decisions affecting the community and supporting them as intermediaries in programme delivery not only improves effectiveness but provides a sense of continuity critical to the normal development of displaced children.

Focus on cultural continuity

It is understandable during displacement crises, with their dramatic human suffering and life-threatening elements, that cultural continuity is not foremost in the plans of international organizations. But the consequences for children deprived of their cultural bearings can be serious, in terms of psychosocial impact and ability to thrive in the post-crisis setting. Among the steps UNICEF and partners can take to maintain cultural continuity are:

- support for traditional community leaders by consulting and working through them;
- co-locating in camp settings and other relocation sites, community and kinship groups;
- support for voluntary religious events, festivals, and rituals;
- support for traditional music, dance and other arts and recreation activities, as well as for traditional skills.

Field-Level Strategies and Actions

Field-level strategies and actions for displaced children are built around the four primary components of all UNICEF emergency work:

- advocacy
- assessment
- care
- protection

Why Culture Is Important

Culture provides children with identity and continuity. By learning the values and traditions of their culture, children learn how to fit into their family, community and the larger society. Each social group has its particular rules concerning who takes care of children, what they are taught at which age, what is expected of children, how they should be disciplined, and what should be done when things go wrong.
This section emphasizes unique elements of displacement that may affect programme design or delivery. At a minimum, UNICEF staff should ensure that programme benefits reaching other children in the country also reach displaced children.

The actual UNICEF field-level program for IDP children will depend on country-specific factors but will focus on the general aims stated earlier:

- a leadership role in advocacy
- prevention activities that diminish the magnitude of displacement
- programmes that ensure survival
- activities to protect displaced children from violence and abuse
- rehabilitation and recovery activities
- return, when feasible, to the communities of origin

Advocacy

Vigorous advocacy for the rights of displaced children depends on accurate information about their condition. There should be no illusion that advocacy work will be easy or universally applauded, especially when displacement is associated with membership in an identifiable religious, ethnic or political group that is party to a conflict. In such cases, advocacy on behalf of the displaced may engender opposition, from government colleagues and other programme partners. Balancing UNICEF’s advocacy role with the potential long-term costs to children of undermining development programmes requires keen analysis. Action steps should be shaped by UNICEF’s bedrock role as the primary advocate for children, especially, highly vulnerable groups like internally displaced children. Important actions include the following:

**Field Level strategies all derive from UNICEF’s policy:**

“to ensure that children displaced under emergency conditions have the same rights to survival, protection and development without discrimination as other children.”

**Advocate to educate:** Authorities, donors, opinion leaders and other advocacy audiences concerned about emergency conditions in the country may understand shortfalls in food, medicine, shelter and other essentials. Few will fully comprehend the assault on children’s rights caused by the trauma of displacement or fully appreciate the critical role of supporting family and community institutions. UNICEF advocacy efforts should emphasize these critical elements.

**Focus on durable solutions:** While the survival of displaced children and their protection from violence are crucial, as are efforts to restore normalcy during displacement, UNICEF advocacy efforts should remind audiences that durable solutions – especially return to home communities, when feasible – is the ultimate objective of all efforts.

**Target national leaders:** In conditions of internal displacement, national authorities – the government in power and those aspiring to power – retain responsibility for the well-being of their citizens, among them children who have been forced to flee their homes. Although advocacy can be addressed to multiple audiences inside and outside the country, the focus should remain on those leaders who have the authority and responsibility to address the conditions of the displaced, prevent abuses of children, guarantee access, ensure that IDPs return to their communities, and address underlying causes of displacement. Advocacy should target civilian and military leaders.

**Focus advocacy on the displaced themselves:** Training and awareness-raising to make the affected population aware of their rights can mobilize pressure for durable solutions. Such efforts can be especially valuable for the psychosocial well-being of displaced communities experiencing a sense of powerlessness.

**Advocate to mobilize resources:** Few dedicated funding streams or donors – justifiably concerned with measurable results – commit resources to populations on the move or in hiding. Therefore, advocacy efforts must be planned to raise donor awareness in order to guarantee the substantial resources needed to serve the displaced.

**Continue advocacy during ‘static’ displacement:** Media and public attention may spotlight the displaced during crisis periods of extreme deprivation, requiring relatively modest advocacy efforts. After conditions stabilize, displaced children may face continued severe problems – stigmatization, disruption of schooling,
military or criminal recruitment, psychosocial problems, sexual abuse, loss of land tenure or other legal rights – that may appear less dramatic or be less visible to outside observers. UNICEF advocacy efforts should ensure that these ongoing serious issues receive attention and resources.

Assessment

Assessment, monitoring and evaluation activities are, obviously, the foundation of sound programs, as well as the basis of effective advocacy. Collecting data on internally displaced children may require extraordinary efforts in overcoming limits to access, uncertain legal standing or simply difficulty in finding them and following their condition over time, especially in conditions of conflict or repeated displacement. Planning for and allocating resources to carry out assessment are critical to effective interventions. Important actions include the following.

Develop indicators of potential displacement: Early warning systems focused on assessment of community tensions can help prevent displacement, limit its scope or, at a minimum, assist in an effective emergency response. Developing such indicators and monitoring systems should be part of assessment planning in countries where indications of potential displacement are present.

Establish pre-displacement baselines: Following large-scale displacement, the absence of useful baselines hampers ongoing assessment work. Where there is a high probability that displacement will occur, even rudimentary baseline data from prior to the emergency may be a wise investment.

Design tools with maximum flexibility: Populations on the move, dispersion of families and communities, children taken in by extended family, and conditions of multiple displacement make accurate assessment extraordinarily difficult during displacement emergencies. The architecture of surveys and other assessment tools should accommodate radically differing conditions likely to be faced by children during the period of displacement.

Plan to assess area of return: Maintaining a focus on durable solutions, including the return of IDPs to their homes, requires planning and budgeting for surveys of conditions in areas of return. Such data will assist in planning the return, advocating with authorities for return, and planning community programmes upon return.

Include protection issues in assessments: The extreme vulnerability of displaced children to many forms of abuse requires assessment of their physical safety and psychosocial well-being, efforts at recruitment and other human rights violations, in addition to nutrition, health and other traditional measurements. Such data should be organized by gender and age-group.

Pay attention to cultural factors: The maintenance of cultural and religious practices provide a psychological boost and respite from the demands of displaced life, and supports community continuity, helping provide children with a more stable, nurturing environment. Assessments should determine whether cultural traditions are continuing and what would be required to maintain them.

Involve the displaced, including children: Members of the displaced community – including children – should be involved in the design and conduct of the assessment process. Assessment without such input should be viewed with wariness. At the same time, UNICEF staff should be sensitive to IDPs vulnerability, which may affect their open participation in data gathering.

Coordinate efforts with partners: Assessments during displacement emergencies are difficult, costly and time consuming. Duplication, conflicting or incompatible data – the result of many agencies responding to their separate notions of the emergency – is especially wasteful and counterproductive during displacement. UN and outside agencies should ensure that initial assessment and the establishment of monitoring systems are coordinated.

Care

Care of internally displaced children focuses on the most life-threatening problems. UNICEF, through its programming, collaboration and advocacy, attempts to ensure that emergency nutrition, water, hygiene, health, and non-food relief services reach the most vulnerable, even if target groups have relocated away
from their communities, are in a transient or camp status, or are on the move. The following actions should characterize care efforts.

Pre-planning and coordination to save lives: If there is early warning of potential displacement, meetings with government officials, community leaders and program partners should begin immediately to develop possible steps to head off or diminish the scope of displacement. If displacement appears inevitable, information sharing, task allocation and resource mobilization among programme partners should be the highest priority. The early stages of a mass displacement will generate the greatest loss of life. Ensure that emergency pipe-lines are capable of meeting anticipated needs for potable water, food, medical supplies, shelter supplies, and similar items.

Anticipate, and budget for, extraordinary efforts: Emergency care to the displaced requires special efforts, which may include:

- extraordinary attention to transportation, warehousing and other logistics issues, including detailed knowledge of transportation modes, recruitment of specialists, and, possible coordination with military units
- procurement of maps or satellite imagery to trace group movements
- knowledge of program partners and their capabilities, operating in regions where displaced may relocate
- allocation of additional staff and support resources
- specialized technologies, such as mobile cold chain systems
- substantial investment in communications equipment

Liaison with traditional and non-traditional partners: Ensuring that emergency care reaches the displaced requires extensive liaison with leaders of the displaced community, with programme partners, and with civil and military authorities. Detailed negotiations over access and a special focus on equitable distribution – especially for vulnerable groups like children and women-headed households – may be necessary.

Plan interventions to support community structures: During displacement, community structures – family units, traditional hierarchies, social responsibilities – will become frayed, increasing stress on displaced children. These can be strengthened through the design of appropriate interventions, which use traditional leaders and established systems for distribution of supplies, etc. Ensure, in consultation with community leaders, that such systems do not inadvertently offer incentives for families to disperse.

Anticipate family dispersion during displacement: Every effort should be made to keep families together through design of shelter arrangements, allocation of food and relief supplies, protection from military recruitment, etc. Nonetheless, children become separated from parents. Anticipate and plan measures for family reunification, even in the early stages of displacement. A number of NGOs have developed significant expertise in family tracing and unification programmes. Engage them quickly. Be especially sensitive to the conditions of girls, single women or women heads of households who may be especially vulnerable to abuse or discrimination in the receipt of goods. Consult with community leaders, especially women, on community-based systems that will ensure adequate care for all individuals separated from families.

Identify high-risk groups: Unaccompanied children, child targets of military recruitment or sexual abuse, and other high risk groups are most vulnerable during the chaos of initial displacement. Plan for and devote resources immediately to locating high-risk groups and to designing community-supported measures for their care and protection. NGO partners may be of special assistance with these tasks.

Mobilize resources within the displaced population:

- Highly skilled individuals – community leaders, medical personnel, midwives, teachers, professional administrators, child-care professionals, psychologists, skilled tradesmen, and many others – are likely to be found within the displaced population.

Optimize the location of displacement: The initial location to which displaced individuals flee may be determined more by escape from danger than by long-term viability. They may be found in unhealthy,
inaccessible areas like high mountains, river areas or deep forest. Consult immediately with leaders of the displaced community, programme partners, national authorities, military commanders, opposition groups, and local and international NGOs to locate sites that will combine safety with physical sustainability. Design emergency distribution systems to avoid settlement in unhealthy or unsustainable locations. Assume that the displaced will stay in this location for some time, perhaps months or years. Make sure the site provides not only water and adequate drainage but agriculture land and access to markets that will help sustain displaced communities over time.

Recognize the costs of stigmatizing the displaced: Clearly, the displaced have special needs. Yet, specialized treatment of displaced populations – especially in conditions where the general population has been affected by war or other emergencies – can lead to stigmatization, and can engender hostility from surrounding communities. Where possible, efforts to meet the essential needs of displaced children and their families should be combined with broad–based community efforts to reach all those in need. For example, construction of school buildings for displaced children can be combined with an assessment of overall education needs in the displacement area, to ensure that all children, resident or displaced, have equal access to basic learning.

Remember education: Ensuring the survival of displaced children and their protection from direct violence remain the highest priorities during displacement emergencies, and are likely to be the focus of attention by donors and partner organizations. UNICEF staff must then make special efforts to advocate for the importance of continued education. Even rudimentary educational facilities, both in the area of displacement and the area of return, offer a sense of continuity, provide hope and help prevent future stigmatization of displaced children. Accurate record–keeping to support re−enrollment in the area of return should be part of schooling. Efforts should target government education authorities to ensure that they extend available educational facilities to displaced populations.

Begin planning immediately for return: At the same time that it is necessary to prepare for the worst case, that is long−term displacement, it is essential to devote planning and resources to support return to home communities. IDPs may have begun to return to homes immediately after a flare−up in tension or violence. In some cases, return will be voluntary, with little or no assistance required from the international community. In cases of extensive distant or long−term displacement, considerable assistance may be required. The following in Panel 1 can assist in planning return activities.

Protection

Protection of displaced children focuses on shielding them from physical and psychosocial harm inflicted by others, such as violence, exploitation, sexual abuse, neglect, cruel or degrading treatment, or recruitment into military forces. Displaced status makes children especially vulnerable to each of these forms of abuse. Protection also preserves the identity and cultural, linguistic and inheritance rights of displaced children, who, removed from their home communities, are at significant risk of losing those portions of their heritage.

UNICEF's approach to child protection in emergency settings is detailed in a separate chapter of this handbook, which should also be consulted. Starting with the solid foundation provided by the Convention on the Rights of the Child and local traditions, UNICEF must build additional protection capacity, including staff training and skills development, in order to fully protect displaced children.

Currently, however, there is much that UNICEF can do to help protect displaced children from abuse. Protection in displacement emergencies can include direct intervention, or advocacy to governments and other organizations to spur their protection work. Especially helpful is collaboration with UNHCR, the International Committee of the Red Cross, the UN Centre for Human Rights, peace−keeping forces, and NGOs active in protection activities. UNICEF has an especially important role in ensuring that such organizations are aware of and focus on the special needs of displaced children in their ongoing protection activities.

Physical protection of displaced children: UNICEF activities may include promotion of areas where there are displaced children as ‘zones of peace’, physical protection, monitoring and reporting of violations, creating protected areas or ‘corridors of tranquillity’, evacuations, securing release of detainees, and other representations to authorities on behalf of displaced children (see Panel 2).
Focus on Identity Issues

Conditions of displacement, especially if the child is a member of a minority or opposition group, may complicate efforts to register births, or otherwise establish the child’s identity and full citizenship. Protection activities should ensure that basic identity and registration documents are provided, and that government legislation and policies accord full citizenship to displaced children regardless of cause, including those born during displacement. Protection of these rights helps ensure non-discrimination in future schooling, employment, participation in civic functions, or other legal rights.

Focus on cultural and linguistic rights: Children’s cultural heritage will be severely tested by conditions of displacement. Because the most durable solution is return to the home community, protection of traditional community social structures, culture and language have important psychosocial and practical value.

Focus on children’s rights after return: Displaced children returning to their home communities may face a range of challenges to their rights. Among these are the uncertain legal status of orphans, attempted prosecution of children required to perform military service while displaced, and property rights issues, especially the ownership or inheritance of land. Unaccompanied minors or children in female-headed households also face particular problems. Begin addressing these issues with adequate registration procedures during the period of displacement and during negotiations with community and leaders prior to and after return.

Coordination and Partnerships

Coordination Principles

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<th>Article 7 of the CRC ensures the right of all children to:</th>
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<td>“be registered immediately after birth and...the right from birth to a name, [and] the right to acquire a nationality....”</td>
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<th>Article 8 ensures that:</th>
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<tr>
<td>“States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.”</td>
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As this handbook goes to print, enhanced IDP coordination within the UN system at the field and global levels is the topic of intense discussion, but optimal coordination remains elusive.

This fluid IDP management environment also implies that unique coordination models will evolve in each country setting, demanding immediate, intense, regular, systematic and ongoing field-level inter-agency communication. For example:

- the Resident Representative may take a coordination role;
- a ‘lead agency’ for IDPs may be designated;
- an IDP working group may be formed among resident international agencies, when the magnitude of the displacement emergency requires so.

Partnerships

Partners for work with IDPs – especially in emergencies involving armed conflict – include both traditional UNICEF emergency colleagues and non-traditional partners.

Displaced community leaders, family heads, children: The displaced themselves remain the single best partner for assessment of needs and programme delivery.
Local NGOs and community organizations: These groups, especially if they have been displaced themselves, provide an essential interpretation of local economic, cultural and social issues that will optimize programme planning, and may provide important information on locating and accessing displaced communities. Local human rights groups, or committees focused on CRC implementation, may be especially useful in advocacy and protection work.

The essential coordination imperative for UNICEF is that displaced children must never become invisible, must never ‘fall through the cracks’. When conflict or other circumstances leave children displaced, UNICEF may not always take the lead in providing every category of services and care. UNICEF should always be recognized, however, as the leading advocate for displaced children, based on a thorough assessment of their condition.

The national government: Especially in the chaotic ‘crisis displacement’ phase of an emergency, coordination within the international community may require extreme effort, and national government resources may be overlooked. UNICEF, bringing a developmental, capacity-building perspective to all emergency work, and cognizant that national governments have primary responsibility for their internally displaced citizens, should ensure that national governments are encouraged and supported in taking a lead role on behalf of the internally displaced.

Opposition groups: While cognizant of the legitimate authority of the national government, UNICEF recognizes that displacement emergencies frequently result in IDPs locating in areas outside the effective control of the national authorities. Early impartial and above-board liaison with opposition groups, including military commanders, may be critical to accessing groups of displaced children and ensuring their protection.

International NGOs: International NGOs, especially those operating in the country prior to the emergency, remain an excellent source of information and implementing partners.

The International Committee of the Red Cross: Although the ICRC will focus on all children impacted by conflict, rather than the displaced per se, they are likely to be present in force in major conflict–related displacement emergencies. Coordination between the UN agencies and the ICRC to optimize service delivery to displaced communities and to coordinate protection/advocacy efforts (in areas of international humanitarian law) are essential.

The UN Office for the Coordination of Humanitarian Affairs (OCHA): OCHA has been designated the focal point within the UN system for headquarters coordination of IDP issues, including global advocacy, data management and consolidated appeals. UNICEF’s close coordination with OCHA is essential as the Office develops this evolving mandate.

The UN High Commissioner for Human Rights (UNHCR): In the areas of advocacy on behalf of and protection of the displaced, the Office of the High Commissioner serves as an excellent resource for legal norms and principles and, increasingly, as a source of monitors and reporters present in the field during emergencies.

International, regional, and local human rights organizations: As the world community has increasingly focused on the human rights aspects of armed conflict emergencies, human rights organizations present during conflicts become important to UNICEF in two ways: first, as partners in advocacy and protection work; second, as recipients of UNICEF assessment data, reporting on abuses and advocacy work on behalf of displaced children. Such groups may not immediately focus on the CRC and children’s rights issues; their presence provides an opportunity for UNICEF to mobilize additional resources on behalf of displaced children.

Peacekeeping forces (UN, regional, bilateral): UNICEF liaison with military units on peace-keeping duty offers two avenues to benefit the internally displaced: first, training and awareness raising of peace-keeping forces may avoid unintentional abuses of displaced populations by those forces themselves; second, the forces may offer logistics support (in crucial sectors like landmine removal) to programmes for the displaced, may facilitate communications with national or opposition military leaders with whom they are in contact and, in extreme cases, peace-keeping forces may open access to communities of the displaced that are otherwise isolated due to security issues.

UN High Commissioner for Refugees (UNHCR): As is obvious from the number of citations in this chapter, UNHCR has done much work with refugee populations that has application in meeting the needs of internally displaced children. In addition, UNHCR has been designated, in several country settings, as the lead UN agency for the internally displaced, and has developed considerable expertise on IDP issues. UNICEF and UNHCR have concluded a memorandum of understanding spelling out coordination steps vis-à-vis IDP
children. UNICEF field staff should actively coordinate with UNHCR staff to optimize work on behalf of IDPs in the country setting.

The International Organization for Migration (IOM): This Geneva–based organization with special expertise in transportation of displaced populations has become active in resettlement programmes for IDPs. IOM is an obvious interlocutor for UNICEF on the special needs of displaced children during transit.

UN Office for Coordination of Humanitarian Affairs (OCHA), World Health Organization (WHO), World Food Programme (WFP), UN Development Programme (UNDP), UN Volunteers (UNV), and other UN agencies: Depending on in–country presence and the specific circumstances of the displacement emergency, the sister agencies of the UN system – those mentioned above and numerous others with significant expertise and resources – are obvious potential partners in areas of substantive expertise. As mentioned above, absent a clear–cut IDP management system within the UN, inter–agency communication and clarity of responsibility are essential.

The media: In all aspects of work with displaced children – advocacy, protection, care, even data gathering/assessment – local and international media can be powerful partners. Since the displaced can so easily disappear from the view of government leaders and others responsible for their welfare, use the media to maintain the spotlight on conditions, needs, abuses, and program successes.

Further Guidance


Deng, Francis, *Guiding Principles on Internal Displacement*, Office for the Coordination of Humanitarian Affairs (OCHA), February 2000


Panel 1 – Planning Return Activities

**PLANNING RETURN ACTIVITIES**

- Have detailed consultations been conducted with displaced community leaders about the costs and benefits of return?
- Are displaced community leaders assured that the home area is safe? Do they require additional resources, like assistance for site visits or escorts, to assure themselves of its safety?
- Do community leaders have a clear understanding about how children will adjust in the area of return?
- What do community leaders think will be essential to ensure the well-being of children in the home area?
- Is the desire to return to home areas without being coerced by authorities?
- Have issues of demining and unexploded ordnance been addressed?
- Have long-term issues, like reconstruction of destroyed essential infrastructure, been addressed?
- Have consultations to resolve outstanding issues been conducted between displaced communities and those remaining in the area of return?
- Are there cases of housing or farmland being taken over by resident communities?
- How will they be resolved?
- How will transport be accomplished? Are there issues of permits, government concurrence or negotiations with armed factions?
- Who will ensure adequate care, including water, food and medical treatment, during the return trip? Who will ensure that family units remain together and that special needs groups (unaccompanied children, handicapped and others) receive care in transit?
- Are the displaced themselves prepared for the return? Has there been adequate dissemination of information – including to children – about plans for return? Are family units grouped together?
- Has medical screening been accomplished to identify medical problems that may occur in transit or immediately upon return?
• Are children’s essential records in order? Are birth certificates and related identity documents completed, to avoid problems upon return? Are immunization records intact? Are schooling records complete, to avoid stigmatization or discrimination upon return?

• How will the displaced survive during the initial months of return? What provisions exist for water, food, health care, and education? What is the condition of shelter?

• What provisions are in place to assist in the re-establishment of livelihoods? Are seeds and tools available for farmers? Does the community require specialized ‘kits’ to resume essential community services like carpentry, masonry, funeral care, and tailoring? Are essential markets still functioning?

• Are there guarantees that returnees will have access to available medical and other services? Will returnee children be guaranteed non-discriminatory admission to schools and other services?

• What provisions are in place to monitor the return and the condition of the community, including children and especially vulnerable groups, in the months following the return?

Panel 2 – Physical Protection of Displaced Children

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<th>PHYSICAL PROTECTION OF DISPLACED CHILDREN</th>
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<td>The following checklist, adapted from UNHCR’s Guidelines on the Protection and Care of Refugee Children, should be used to guide protection work:</td>
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</table>

| • What are the security threats to displaced children? |

| • Have any displaced children died? If so, from what causes? What actions might have prevented these deaths? |

| • Are any displaced children physically or sexually abused, tortured, abducted, recruited for military service, or are they victims of any other forms of abuse or exploitation? Is there significant risk of such abuse or exploitation? |

| • Are any displaced children in jail, prison, long-term closed camp confinement, or in any other form of detention? |

| • Have effective steps been taken to prevent further abuse or exploitation of displaced children? |

| • Are remedial services available to all victims of abuse or exploitation? |

| • Are responsible national authorities fully aware of threats to the personal security of displaced children? |

| • Are national law and order systems providing the protection required? Does this protection effectively reach displaced children? |

| • What additional measures would strengthen security systems? |

| • Is an effective international presence being maintained in situations where there are threats to displaced children’s security? |

| • What advocacy efforts would enhance the safety and liberty of displaced children? |

| • Is training being provided for displaced leaders, government officials, security personnel, other UN agencies, and NGOs on special protection considerations for displaced children? |

| • Are incidents of abuse, military recruitment and detention of displaced children being monitored and reported? |

| • Is it necessary to change the location of the camp or place of residence of displaced families to enhance protection of children from abuse or exploitation? |
Chapter 6: Anti-Personnel Landmines

Rationale

The time-delay function of landmines, their clandestine deployment, indiscriminate nature and unpredictability make them an insidious and deadly weapon. In addition to inflicting physical and psychological damage on civilians, landmines disrupt and increase the costs of social services, threaten food security by making fertile land lie fallow, hinder the return and resettlement of refugees and internally displaced persons, and deter relief assistance in emergency situations. As such, the landmine crisis should be understood as both a humanitarian and long-term development issue.

Landmine usage has increased dramatically over the past 20 years, targeting civilians with an intent to terrorize as well as deny them access to farmland, irrigation channels, roads, waterways and public utilities. The indiscriminate use of anti-personnel landmines is a flagrant violation of international human rights law, including the Convention on the Rights of the Child (see, inter alia, articles 6, 38, and 39).

UNICEF calls for an integrated landmine action strategy to combat the scourge of these insidious weapons. This approach is both preventative and curative, aiming to address the problem with long-term sustainable solutions.

UNICEF’s overall aim is to foster an environment in which children can live and develop safely, and where economic and social activities can be pursued freely without the threat or constraints of landmine contamination. As such, mine action strategies should be understood as a means towards this wider developmental objective, rather than an end in and of itself.

Vulnerable Populations

Landmine victims tend to be concentrated among the poorest sectors of society, but vary in their cultural and ethnic composition, geographic location, political status and history. Such factors, combined with different mine types, dispersal patterns and status of the military operations, determine the risks they face. The differing needs of vulnerable populations should determine the actions taken.

According to the ICRC, millions of landmines lie uncleared in over 68 countries. They indiscriminately kill or maim an estimated 26,000 children, women and men each year, 80 per cent of whom are civilians, and 30 to 40 per cent of whom are children.

Rural-based communities: Those living in a landmine-infested region are at extremely high risk as they engage in daily sustenance activities such as cultivating fields, herding animals and searching for firewood. In many cultures, children carry out these tasks, making them particularly vulnerable to landmine injury or death.

Urban communities: They are also at risk, as landmines may be planted in abandoned buildings or military outposts. Poor urban children working as scavengers, may come across unexploded ordnance (UXO) in their search for metal to sell in the market. Such weapons can explode unexpectedly while being held by unsuspecting hands, causing loss of limbs, blindness and/or death.

Refugees and internally displaced persons (IDPs): These populations are particularly vulnerable to landmine accidents due to their unfamiliarity with mined areas upon flight or return. Returnee communities may have little option but to resettle in mined areas, as mine-free land may have been occupied in their absence. For many displaced communities, the prevalence of landmines in their home regions may deter their return, prolonging their exile.
Populations living in conflict zones: These face the additional danger of the ongoing laying of mines. Areas deemed clear of mines may, suddenly without warning, become infested. Such conditions severely constrict freedom of movement and the ability of such populations to be safe and secure.

Vulnerability of Children

Children comprise as much as 30 to 40 per cent of civilian landmine victims. They are particularly vulnerable to serious mine accidents due to social, developmental and physical factors:

- Young children may have more difficulty recognizing or spotting mines or minefield warning signs than adults have.
- Given their ‘natural curiosity’ children are more likely to pick up unfamiliar objects, such as colourful ‘butterfly’ mines, which look like toys.
- Children are more likely than adults to stray off cleared roads into minefields.
- With repeated exposure to mines over time, children may become desensitized to their dangers and use them as toys or in games of bravery.
- In agrarian-based communities, children often carry out daily tasks such as collecting wood and water. In mine-infested areas, such activities put them at increased risk of injury and death.
- In military contexts, child soldiers are more likely to be ordered to venture into known minefields, as their lighter step, dexterity and lack of seniority make them prime candidates for such deadly tasks.
- Given their small size, children’s bodies are closer to the centre of a blast and therefore they are more likely to die from their mine injuries than adults. Those who survive suffer severe physical and psychological injury.

Mine Facts

Often buried below the ground or camouflaged in grassy plains or beside river banks, mines are almost impossible to see. They come in different shapes and sizes; may be made of metal, plastic or wood; and can have varying explosive capabilities. Sometimes technologically crude instruments, mines often malfunction by detonating unexpectedly or not exploding upon initial contact. Mines cannot distinguish between the step of a child and that of a soldier, and as such pose a serious threat to civilian populations.

Types of mines

Mines can be categorised in a number of ways, for example, by type, location, appearance, effect, or method of operation. In this chapter, mines are described in the most basic way, that is, by the location where they are found, below ground or above ground, rather than as anti-tank or anti-personnel, or blast or fragmentation mines.

Mine Proliferation

For all the millions of landmines planted around the world, equal numbers are stockpiled around the globe waiting to be planted. Several hundred types of mines had been produced by over 100 countries. The proliferation of landmines can be accounted for in part by their easy and cheap production costs (US$3–$30 per mine), as well as their easy deployment and their ready availability.

Below-ground mines: Below-ground mines are usually placed only a few centimetres beneath the surface of the ground and are designed to detonate when someone or something exerts pressure on the top. ‘Anti-handling’ devices are incorporated into some mines; for instance, an anti-tank mine may have a tilt
mechanism incorporated that will cause the mine to detonate if the mine is tilted 10 degrees of more. If a below-ground mine is laid properly it cannot be detected by sight, although it may become partly exposed through the action of wind or rain or the drifting of sand.

**Above-ground mines:** Some types of above-ground mines have tripwires connected to the fuse that set the mines off when the tripwire is pulled or cut. A tripwire may be attached to an above-ground mine on one side of a path, then strung across the path and attached to a stake or tree on the other side. These types of mines are commonly mounted on a wooden stake, which may rot, causing the mine to drop and making it more dangerous. Tripwires are typically very thin and are found in several colours and in non-reflective metal so that they easily blend in with sand or grass, and sometimes the above ground mines themselves are hidden behind trees, hung in trees, partly buried with just the fuses exposed, or hidden in tall grass. Consequently, above-ground mines may be almost as difficult to see as below-ground mines.

**Unexploded ordnance (UXO):** These include discarded mortars, rockets, shells, bullets and grenades. While not technically considered mines, UXO pose a similar danger to civilians. It is extremely unstable and can be detonated by the slightest touch. Usually UXO cause much more destruction than do landmines.

**Fuses:** Fuses are fitted to rockets, mortars and shells and set these off. A fuse may also become detached from the explosive device or munition, or it may simply be left lying around. A fuse can be very small, but is nonetheless potentially dangerous and can even be deadly.

**Booby traps:** These can be hidden in any object (a watch, radio, bicycle) and explode when handled. They are often found in abandoned houses or buildings.

UNICEF’s mine-action strategy specifically targets APMs and UXO, which pose the most immediate threat to civilians.

**Mine Dispersal**

Anti-personnel mines are often laid in regular patterns and are most likely to be found:

- around villages and water points
- along roads and river banks
- on bridges and at cave entrances
- near single trees
- around schools and hospitals
- in abandoned military outposts and battlefields

However, mines may also be dispersed randomly, either by hand or scattered by helicopter or artillery. The random dispersal of mines is exacerbated by environmental conditions such as storms or shifting sands, which may cause mines to move over time. After many years of conflict, one cannot be sure which areas are clear of mines, increasing the danger to civilians.

**Detonation**

Mines may be detonated by:

- stepping on or putting weight on the top of a mine
- tripping or pulling on a loose wire attached to a mine
- cutting or pulling a tight wire attached to a mine
- removing a heavy object that has been placed on top of a mine
- touching or tilting a mine

**Mine Clearance**

Once laid, a mine may remain active for more than 50 years. As such, their effects are felt long after hostilities are over. Mine clearance is an expensive and lengthy process. Weapons costing as little as US$3 to
purchase, can cost up to US$1,000 to remove. Landmines can be blithely spread at rates of over 1,000 per minute, but it may take a skilled expert an entire day just to clear by hand 20–50 square metres of mine contaminated land.

Mine warning clues

Despite the fact that mines are difficult to see, there are warning clues that may alert to the presence of mines. The absence of such clues, however, does not guarantee that mines are not in the area. Warning clues include:

- injured or dead animals;
- a partly exposed mine;
- an intact or broken tripwire;
- a fuse sticking out of the ground or lying on the ground;
- a mine packing box or mine wrapping paper on the ground;
- discarded mine safety pins or detonator keys on the ground;
- an unusual change in the vegetation, an unusual mound, or a small hollow caused by shifting sand or settling soil;
- signs of fighting, such as bomb craters, shrapnel lying about, or bullet casings;
- a lack of signs of the recent passage of people.

Consequences of Landmines

Impact on survivors/amputees

Children who survive mine accidents are subject to a long and painful recovery process. Because their limbs are still growing, injured children may require repeated amputation and must be fitted with new prosthetics every six months. Such procedures as these place an enormous, often impossible, financial strain on the majority of poor victims and accompanied by long and painful physical rehabilitation processes, which costs thousands of dollars, often propelling their families into debt.

For rural amputees, the perceived advantages of receiving a limb must be balanced against the loss of work as a result of time away from the village in order to recover and be fitted with a limb, and the subsequent impact on the family economy. In many cultures, men may have priority in care and in receiving new limbs. The skewed consequences of these gender-driven decisions often marginalize women and children in their hope for leading productive lives and being accepted back into community life.

Social stigma

The social stigma attached to mine victims varies across cultures. In many cases, they suffer discrimination in areas such as the labour market, where they have difficulty finding work, and in the social sphere, where they may be seen as undesirable (and unproductive) marriage candidates. For child amputees, missing limbs may mark them as unproductive members of the household. They may be perceived, or perceive themselves, as a burden. Such stigma, combined with the traumatic physical and psychological effects of injury, has indelible psychosocial impact on the individual, making their reintegration into society difficult.

Indirect effects

Mine Injuries and Death

Landmines may cause the severe injury or death of their unsuspecting victims. Given their small size, children are more vulnerable to landmine injury and death than adults. Those who survive must often live with
the consequences of a lost foot, hand or leg, injuries to the genitalia and even blindness.

Even when children are not the direct victims of landmines, they are often forced to forego their education to take care of their injured parent or assist with the cultivation of crops or with household chores.

In addition to the emotional stress surrounding the death and/or maiming of a loved one, the child’s role in the family and community structure may change dramatically. For example, in agrarian societies, it may be difficult for a mine victim to carry out normal economic activities such as farming. This increases the economic vulnerability of the family and may necessitate children’s premature entry into the labour force. The child’s role may also shift from one of a dependent to that of a caretaker or nursemaid to an injured parent. In both cases, the new demands on the child’s time may prevent her/him from attending school and having a nurturing childhood.

Socio–Economic Consequences

In addition to the direct and indirect effects of landmines on millions of children and their families, the long–term socio–economic consequences to the community are devastating. These include the following.

Draining medical resources: In countries where the medical infrastructure is rudimentary, landmine victims may drain the limited medical resources. Victims need far greater blood transfusions than other war casualties. Medical training in amputation, and the anaesthetics designed to lessen such a traumatic operation, may be limited or non–existent. Ultimately, it is mine victims who suffer the consequences.

Increasing agrarian poverty: Mine–infested land is rendered unusable for agricultural production. This increases food dependency and lowers the nutritional status of these communities and plunges them into deeper dependence and poverty.

Weakening of national infrastructure: The existence of mines around electrical plants and water irrigation systems, for example, makes repair impossible and thus limits the delivery of such services. Furthermore, mine–infested transport routes limit the circulation of goods.

Decreased quality of life: These combined factors effect unemployment, which rises, as do prices of scarce resources. Such conditions lead to a decrease in the ‘quality of life’ of a community, which has a direct negative effect on its children.

Impediment to post–conflict reconstruction: Furthermore, mines serve to severely impede post–conflict reconstruction and development. It is in this sense that the landmine crisis can be understood as a long–term development issue.

Hindering of relief assistance: In emergency situations, the existence of mines along roadways and transport routes may prevent or slow the delivery and distribution of relief supplies. This may lead directly to increased child mortality and morbidity rates through limited access to food and essential medicines.

UNICEF Policy and Principles

The existence of landmines deprives children of the chance to enjoy many of their basic rights. These include the right to life, health, protection and a safe environment for work and leisure. UNICEF’s approach to the landmine crisis is informed by the Anti–War Agenda, the recommendations of the Machel Report, the Ottawa Convention and the 1996 Mines Protocol. And it is both inspired and guided by the Convention on the Rights of the Child:

Article 6(2) requires that State Parties ensure “to the maximum extent possible” the survival and development of the child.

Article 38(1) requires that State Parties ensure respect for the applicable rules of international humanitarian law.

Article 23 requires that State Parties recognize the right of a disabled child to special care and ensure the availability of and access to that care.
Article 24 requires that State Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.

Article 39 requires that State Parties are obliged to promote the physical and psychological recovery and social reintegration of child victims of armed conflict.

Field-Level Strategies and Actions

UNICEF recognizes that the problem of mines is part of a wider interrelated group of problems facing post–conflict societies. Landmines must be understood as both an emergency and a long term developmental issue. Mine action programmes must be part of a larger coordinated response. Ideally, an integrated landmine action programme should be implemented by an interdisciplinary mine action team. This coordination includes inter–agency cooperation and information sharing, increased liaisons with national rehabilitation or development groups, and efforts to facilitate sustainable national capacity to address the consequences of landmines and UXO. This will help develop more responsible efficient and effective mine action strategies.

The four pillars of mine action are:

- mine awareness and risk reduction education;
- minefield survey, mapping, marking, and clearance;
- victim assistance, including rehabilitation and reintegration;
- advocacy to stigmatise the use of landmines and support a total ban on anti–personnel landmines.

The benefits of integrated mine action include:

- increased community contact and information;
- participation of relevant parties in prioritization of programme strategies;
- more appropriate programme responses;
- increased programme efficiency and maximizing resources;
- linking action to the larger strategy of long–term development.

For more details on various programme approaches, refer to the United Nations International Guidelines for Landmine and Unexploded Ordnance Awareness Education.

UNICEF Strategies

Given the complex factors related to landmines:

- UNICEF promotes a three–pronged approach which combines advocacy, mine awareness, and victim assistance.

- UNICEF has been involved with the banning of anti–personnel landmines since 1992 and promotes the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti–personnel Mines and on Their Destruction (which entered into force 1 March 1999).

- UNICEF promotes the ratification of the above mentioned Convention through its Field Representatives and National Committees.

- UNICEF supports advocacy through the International Campaign to Ban Landmines (ICBL) and the International Committee of the Red Cross, and encourages governments to enact legislation banning the production, use, trade and stockpiling of anti–personnel mines.

- UNICEF supports and advocates for humanitarian mine clearance and UXO removal activities.

- UNICEF works to develop and implement preventive community–based mine awareness and education for families at risk both during a conflict and as part of the post–conflict
• UNICEF supports the physical and psychosocial rehabilitation of child victims.

Field Actions

Advocacy

Protection from landmines is a shared international responsibility. The majority of countries contaminated by landmines are among the world’s poorest and cannot finance their own mine clearance activities. Added to this is the cost of victim treatment and rehabilitation (an estimated US$750 million for the 250,000 amputees registered worldwide). The majority of countries producing and profiting from landmine distribution are those that can afford to halt as well as prevent further proliferation. UNICEF’s advocacy campaigns help bring attention to such issues and put pressure on governments and donors to fund mine–action programmes. UNICEF’s advocacy actions include the following.

Support of the International Campaign to Ban Landmines: UNICEF continues to support the International Campaign to Ban Landmines (ICBL) a coalition of more than 1,000 non–governmental organizations calling for a total ban on the production, stockpiling, sale, export and use of at least anti–personnel landmines, and for global funds for mine clearance and victim assistance.

Integrated Mine Action Approach

- mine awareness
- education
- mine survey,
- marking, and
- clearance
- victim assistance
- advocacy in support
- of a total ban

Support of regional mine–free zones: In collaboration with the Organisation of African Unity (OAU), UNICEF has supported the development of regional mine–free zones in Africa.

Boycott of mine–production and distribution companies: As part of its Anti–War Agenda, UNICEF has made a commitment not to purchase products from companies that are directly or indirectly involved in the production or sale of anti–personnel mines or components used in their production.

Country office advocacy: UNICEF’s country offices should advocate for national legislation towards a total ban on landmines.

Community mine awareness and education: Due to the expense and slow pace of mine clearance operations, mine awareness is essential and sometimes the only preventative measure for the at–risk community. UNICEF’s ultimate goal in mine awareness is to reduce accidents and death caused by landmines and UXO through the adoption of safe behaviours. A thorough understanding of the factors that affect people’s behaviour around landmines must be developed, in order to promote strategies that will help change high–risk behaviour.

Physical and Psychosocial Rehabilitation

Landmines not only cause horrific physical injuries but inflict sustained injury on the psychological and social well–being of victims, especially children. Child amputees are often prevented from attending school, shunned by friends and family, and forced to come to terms with permanent severe injuries, including the loss of one or more limbs and possibly their sight. Well–conceived integrated programmes to support the physical, psychosocial, vocational rehabilitation and social reintegration of child landmine victims are promoted by UNICEF in collaboration with specialized agencies dealing with mine victims such as WHO and the ICRC.
Maximizing the physical capabilities of the injured party fosters a new sense of confidence and normality in that individual’s life.

Targeting Communities

UNICEF recognizes the vulnerability of socially marginalized groups in receiving adequate physical and psychosocial care due to their position in the social and cultural framework. For example, the cost of investing both time and funding into extensive rehabilitation programmes for women and/or children members of a poor household may outweigh the perceived benefits of such attention. In an attempt to rectify the resulting gender imbalances, UNICEF has specifically targeted prosthetics and socio-economic reintegration programmes towards women and children.

At-risk communities

The promotion of mine awareness is based on the understanding that at-risk communities are characterized by one or a combination of the following:

- The community is not aware of mines.
- The community is not aware of mine-safety behaviour.
- The community is aware of mines and of safety behaviour but persists to engage in at-risk behaviour due to:
  - economic necessity,
  - social pressure,
  - customs and/or attitudes,
  - a sense of invincibility often accompanying survivors of war/trauma.

In order to implement an effective mine awareness programme, the behaviour patterns and underlying influences in the community must be analysed and addressed. Stages in developing such programming are:

- feasibility study
- information collection, needs assessment and analysis
- communication approaches and dissemination
- monitoring and evaluation

Feasibility Study

A feasibility study helps to determine whether a mine/UXO awareness programme is needed, how it might be integrated within overall mine action, and if an agency, body, or organisation is sufficiently well placed to undertake the programme. An objective analysis of the operational realities, including the context for mine/UXO awareness and the organisations and bodies that might be involved, provides a solid foundation for the programme.

Needs assessment, information collection and analysis

Needs assessment is the systematic collection and analysis of information that can help to identify more precisely the populations at risk, the extent of the risk and the appropriate mine/UXO awareness strategy. The cornerstone of the assessment is data-gathering and analysis. Indeed, the systematic gathering and analysis of relevant data are central to the successful development of all stages of a mine/UXO awareness programme. What is important here is a judicious identification of the questions and a determination of the level of accuracy of the answers. This information will be invaluable in defining mine and UXO awareness strategies.

As far as possible data should be gathered continuously throughout the programme implementation starting with the collection of baseline data. The scope and the depth of the needs assessment depend on the financial and logistical resources available to the implementing organisation, as well as on the types of
An integrated needs assessment is recommended and should involve mine-affected communities, local and government authorities, other mine action agencies and humanitarian sectors. For further guidelines on conducting a needs assessment, turn to Annex 1.

**UNICEF supports prosthetics programmes and services including:**

- providing prosthetics and tools for mine victims
- training practitioners in prosthetics and physio-therapy
- integrate vocational training/retraining of mine victims to encourage economic self-sufficiency
- foster psychosocial care to address the self-esteem and reintegration of victims

A detailed framework for planning techniques is provided in Annex 3.

**Communication approaches and dissemination**

The communication approach employed in a mine awareness programme shapes the dissemination of that information and affects its reception. UNICEF identifies two approaches: information dissemination and participatory approaches.

**Information dissemination approach:** This is a one-way flow of information from the ‘expert’ to the target audience, transmitting persuasive messages that define the desired behaviour to be changed. Such an approach may utilize mass media, audiovisual and graphic materials, and ‘village presentation’ tools and techniques.

Most mine awareness programmes are designed to disseminate crucial mine-related information efficiently to a wide audience, often through mass media such as television and radio or through information posters. Others send trained educators to individual communities and schools to give village presentations (utilizing audiovisual and graphic materials), often lasting no more than a couple of hours. Such strategies, while effective in terms of speed and breadth of dissemination, are not sufficient in and of themselves to encourage behavioural change in high-risk communities. This method of disseminating information is generally used during an emergency phase when crucial life-saving information needs to be imparted in a very speedy manner in order to save lives.

However, this should not be used for any long-term programmes, the one-way nature of information flow, and the sometimes pedantic tone of the messages and their heavy reliance on mass media may fail to reach remote impoverished communities with no access to such information channels.

**Participatory/community-based approach:** This refers to a two-way flow of information encouraging dialogue and analysis at the individual and community level, to seek solutions such as beneficial behavioural and practical solutions. This approach may utilize interpersonal techniques and traditional media.

UNICEF promotes a long-term community-based mine awareness strategy aimed at securing behavioural change in at-risk communities. This involves the active participation of the community in the design and implementation of the programme based on their own needs and communication strategies to effectively address those needs. The active involvement of community members builds sustainable capacity at the local level by encouraging dialogue within the community and empowering its members to develop a culturally relevant long-term strategy for awareness and education.

Participatory techniques include:
• face-to-face or group discussions
• child-to-child communication
• traditional media such as community theatre, storytelling, dance, song, and puppets

While participatory techniques are generally more successful in causing behavioural change, they require significantly greater amounts of time and financial investment, reach a smaller audience at a time, and rely on the voluntary contributions of community members, who may be too busy with basic survival concerns to participate fully.

Needs Assessment

The cornerstone of the needs assessment is the systematic gathering and analysis of information which helps to identify more precisely the populations at risk, the extent of the risk and the appropriate mine/UXO awareness strategy. This process is central to the successful development of all stages of a mine/UXO awareness programme. Of course, the scope and the depth of the needs assessment depend on the financial and logistical resources available to the implementing organisation, as well as on the types of information that the assessment is expected to produce.

Information dissemination and participatory approaches may complement each other and can be implemented concurrently. If the objective is to increase awareness of mines and knowledge of safety strategies, then the information dissemination approach should be sufficient. If people are practicing high-risk behaviour despite the availability of mine information, a participatory approach may be more effective. In many contexts, a mix of techniques may be most effective. For a more extensive list of communication strategies, and their strengths and weaknesses of each, turn to Annex 2.

Mine awareness information

Mine awareness campaigns should include both information to increase knowledge (for example, how mines function, how to conduct rescue procedures) as well as to raise awareness (how to recognize mines, tips on safety behaviour). Each mine awareness programme and the information to be included in it should be context specific, with the affected community involved in its design. The essential topics to cover in awareness campaigns include:

• information about mines
• recognizing warning clues and signs
• recognizing mine signs
• safe behaviours

Monitoring and evaluation

Once programmes are implemented, they must be monitored and evaluated to ensure their effectiveness and relevance to the community. Ongoing monitoring ensures the flexibility of the programme to meet with the shifting needs of the community.

If the programme planning cycle does not allow new information about the problem to be incorporated into the designing of the messages, then it is likely that the messages will relate less and less to the actual problem over time. Designing the messages must be flexible, not only geographically and culturally, but also over time.

The community needs to not only participate but experience a measure of social mobilization to stimulate a level of ‘empowerment’ in respect to addressing the threat of mines.

NGOs and UNICEF work in close partnerships. NGOs are seen as the main implementing agencies of landmine strategies. Their importance cannot be underestimated. In many cases where mine action programmes have been implemented, it is the local NGOs that pave the way for effective and sustainable programming.

(See International Guidelines for Landmine and Unexploded Ordnance Awareness Education.)
Further Guidance

*Further Guidance*


Info Data Sheets on Landmines (includes policy, activities & advocacy)


**Persistence of At-risk Activities**

Awareness of mine-related danger may not be enough to alter risky behaviour. For example, economic necessity may require individuals with no other means of survival to knowingly enter mine-infested land to sow seeds, collect food, graze cattle or collect scrap metal. In such cases, either mine-clearance activities must be given utmost priority or alternative income-generating projects must be made available to the affected communities. UNICEF promotes an integrated mine awareness strategy that pays combined attention to these factors as well as promote efforts to change high-risk behaviour.


Monan, Jim, *'The Impact of Landmines on Children in Quang Tri Province, Central Viet Nam'*; research report for the UN study on the Impact of Armed Conflict on Children, 1996


Reyes de Figueroa, Miriam, *PAM – Mine Awareness Project*, El Salvador, UNICEF–Ecuador

Roberts and Williams, *After the Guns Fall Silent: Enduring Legacy of Landmines*, 1995


**UNICEF collaborates with the following agencies and others:**

- Handicap International
- Human Rights Watch
- Medico International
- The Mines Advisory Group
- Physicians Against Landmines
- Cambodia Trust; POWER
- Vietnam Veterans of America Foundation which came together to form the steering committee of an
Panels

Panel 1 – Mine Warning Signs

### MINE WARNING SIGNS

Warning signs can be left to warn others that there are mines in the area. It is important to know the signs used locally and to support and publicize a system of warning signs that can be easily implemented and be recognizable to local populations, particularly children.

These may include:

- a skull and crossbones sign, either carved on or hanging from a tree
- crossed sticks or mounds of rocks
- knotted grass
- official mine warning notices or fenced off areas organized by the military, deminers or community leaders
- a snapped branch hanging from a tree
- things such as plastic bags, pieces of cloth or cans hanging from a tree or on a tree stump
- a sharp stick inserted through a piece of tree bark or on an upright stick of bamboo pointing at the mine
- painted rocks
- whatever you know to be the warning signs used in the local community
- internationally or nationally accepted signs such as a red triangle with a skull and crossbones or military signs with an ‘M’ on a small red triangle.

It is important to always respect warning signs. Never remove them, never walk beyond them. If there are no warning clues or signs, do not assume that the area is safe.

### Guiding Principles

The following outlines a guide to information that a mine awareness programme may wish to convey. Mine/UXO awareness messages must be adapted to the local situation and to local target groups according to the results of the needs assessment, and they must be field tested prior to dissemination. They cannot be drafted without reference to the specific situation.

The most effective messages are those that explain the reasons for recommended actions. Messages do not have to be brief and concise. For example, in communities where returnees are expected, a message might be:
“If you leave the mine signs in place, you will be protecting the lives of the members of your own family who are returning to the village because the signs will warn them that the area is mined.”

Messages should be positive as far as possible. Care should be taken not to give the impression that it is impossible to live safely with mines. Messages should use support from local culture and religion as far as possible, particularly when these may otherwise appear to encourage unsafe behaviour.

One obvious legacy of landmines is the large number of disabled people. In employing images of mine victims to warn populations of the mine danger, one should be sensitive to the place of the disabled in society. It is important to picture mine amputees as survivors who have skills that they can offer to the community rather than as useless victims who should be pitied. Using landmine survivors as instructors and as participants in mobile presentation teams can be a powerful message in itself, though care must be taken not to traumatisé the survivors.

Faced with the daily threat of landmines and with no quick solution in sight, people may feel that the situation is hopeless, and this can lead to complacency. By opening linkages between rural populations and the international/development community, one may be able to encourage people in the countryside to confront mine problems more coherently.

Curriculum Content

With the important proviso that all messages must be adapted to the specific situation, the following points should be underscored in any mine/UXO awareness programme.

a) Be aware of the threat:

- Be able to identify mines/UXO and the fundamentals of how they work.
- Recognise areas likely to be mined.
- Be able to recognise mine warning signs.
- Be able to recognise clues to the presence of mines.
- Learn about the nature of mine injuries.

b) How to protect yourself and others:

- Keep out of known mined areas.
- If you must enter, find out about the safe paths through minefields.
- Stay on a safe path.
- Do not touch mines.
- Pass on information.

c) What to do if you come across a landmine/UXO:

- Mark the mined area and report its presence.
- Use your knowledge about how to get out of a minefield.
- Use the rescue procedures you have learned.

Mine/UXO Awareness Message: Be Aware of the Threat

Identifying mines/UXO and the fundamentals of how they work.

General observations

Significant amounts of time should not be spent on the identification of landmines and UXO since dozens and dozens of different types of landmines and UXO may be found in any one area.

Identifying Landmines and UXO
• Mines and UXO come in many different shapes, sizes and colours. They may be susceptible to rust or change appearance because of weathering.

• Mines and UXO can be made of wood, metal, or plastic.

• Mines and UXO are usually difficult to see. They may be buried, hidden in tall grass, camouflaged among trees, floating on the water, or lying under water.

Below−ground Mines

Mines can be categorised in a number of ways, for example by type, location, appearance, effect, or method of operation. This Handbook describes mines in the most basic way, that is, by the location where they are found, below ground or above ground, rather than as anti−tank or anti−personnel, or blast or fragmentation mines. Below−ground mines are usually placed only a few centimetres beneath the surface of the ground and are designed to detonate when someone or something exerts pressure on the top. “Anti−handling” devices are incorporated into some mines; for instance, an anti−tank mine may have a tilt mechanism incorporated that will cause the mine to detonate if the mine is tilted 10 degrees of more.

If a below−ground mine is laid properly it cannot be detected by sight, although it may become partly exposed through the action of wind or rain or the drifting of sand.

Above−ground Mines

Some types of above−ground mines have tripwires connected to the fuse that set the mines off when the tripwire is pulled or cut. A tripwire may be attached to an above−ground mine on one side of a path, then strung across the path and attached to a stake or tree on the other side. These types of mines are commonly mounted on a wooden stake, which may rot, causing the mine to drop and making it more dangerous. Tripwires are typically very thin and are found in several colours and in non−reflective metal so that they easily blend in with sand or grass, and sometimes the above ground mines themselves are hidden behind trees, hung in trees, partly buried with just the fuses exposed, or hidden in tall grass. Consequently, above−ground mines may be almost as difficult to see as below−ground mines.

Unexploded Ordnance (UXO)

Unexploded ordnance is not mines, but ammunition (grenades, mortars, rockets, shells, or bullets) that has not been used or that has been fired, but failed to explode. This does not mean that UXO is safe. In fact, it is extremely unstable and can be detonated by the slightest touch. Usually UXO causes much more destruction than do landmines. The lethal range of the explosion of a common mortar, for example, is 300 metres, while the explosion of a large bomb may be lethal within a range of 1,000 metres or more.

Fuses

Fuses are fitted to rockets, mortars and shells and set these off. A fuse may also become detached from the explosive device or munition, or it may simply be left lying around. A fuse can be very small, but is nonetheless potentially dangerous and can even be deadly.

Booby−traps

A booby−trap is a familiar object attached to a mine or explosive which is set off if the object is disturbed, sometimes even by movement close at hand. Everyday objects such as a packet of cigarettes, a watch, or a toy may serve as booby−traps. Likewise, a weapon may be used as a booby−trap by placing it on the edge of a path and attaching it to a tripwire connected to a concealed above−ground mine. People should remember never to touch anything unless they are completely certain that it is safe.

The Nature of Mine Injuries

Teaching people about landmine injuries is one method of motivating them to adopt safe, non−high−risk practices in mined areas.
Landmines and UXOs can kill or cause severe injuries, including the loss of limbs. Mine/UXO injuries affect not only the injured individuals, but also their families and communities.

**Physical effects**

- A mine or UXO can kill.
- It can blow off arms or legs, or it can blind.
- A mine/UXO injury can cause a pregnant woman to lose her baby or injure a man so that he cannot father children.
- An injury can affect the ability to walk, stand, jump, play football, or engage in heavy work.

**Economic effects**

- If the breadwinner in a family is injured or killed, the family will suffer through the loss of income and will have to find other means to pay for food.
- A family member who is injured by a mine or UXO will need assistance from the family.
- A mine/UXO victim may have to spend many months in hospital. This consumes valuable community resources, including lost wages and time.
- Mines/UXOs can injure or kill farm animals, and this represents a loss in income as money is needed to buy new stock.

**Psychological effects**

- The survivor of a mine incident experiences a daily struggle to earn an income, to be accepted by the family and the community and to lead a normal life.
- The mine victim may lose family support.
- The victim may be unable to cope with the emotional and financial strains linked to the injuries, including feelings of guilt for the pain that the injuries bring to other family members.

Landmine/UXO Awareness Message: How to Protect Yourself and Others

**Keep out of mined areas**

It is vital to be constantly on the lookout for mine warning signs and clues that might indicate that an area is mined. Suspected mined areas should not be entered until they have been properly checked and cleared. Nonetheless, people may feel the need to enter known or suspected mined areas in order to gather wood or water. Everyone should therefore be fully informed of mine/UXO awareness techniques. Everyone should also be encouraged to seek safer ways to find or pay for food. Skills training, the increased availability of food supplements, and food-for-work schemes are indirect means of accomplishing this.

- Look out for warning signs and clues which could indicate whether an area is mined.
- Do not enter known mined areas for any reason.

**Do Not Touch Mines/UXO**

“Do not touch mines because...!” is an important message and must be repeated in different ways over and over again. One method of helping children understand that they are not to touch mines/UXO is by making sure that no teacher or landmine awareness staff is ever seen touching or holding any mines or UXO, whether real or merely models. This should apply to photos and to individuals pictured in illustrations as well.

**Do not touch mines! Do not enter dangerous areas!**
• Do not throw a mine or throw anything at a mine.
• Do not kick or otherwise strike a mine/UXO.
• Do not touch any object unless you are absolutely sure it is safe. It may be booby-trapped.
• Do not attempt to de-fuse a mine or de-mine an area.
• Warn others not to touch mines.
• Prevent others from entering mined areas.
• Do not throw a mine/UXO into water.
• Do not burn a mine/UXO.
• Do not go anywhere near a tripwire, as the surrounding area may also be mined.
• Do not attempt to collect mines/UXO for scrap metal.

**Ask Locals about Safe Paths**

A safe path is one that is travelled frequently and is known to be free of mines or UXO. When travelling far from home, one should regularly inquire about the location of mined areas, as these locations may change. Nearby residents usually know which routes are safe and which are not, though it may be necessary to ask several people to be sure. One should travel by day whenever possible because it is harder to see warning signs and clues at night. Moreover, mines are often laid at night. Although they are usually removed in the morning, soldiers may sometimes forget to do this.

- Ask the local people about the safest paths.
- Travel by day whenever possible.
- If you are unsure whether a road or path is safe, do not use it, but seek a safer route.

**Stay on the Safe Path**

When travelling in potentially mined areas, under no circumstances should one leave a safe path, even to go to the toilet. Always look for clues of the presence of mines. Why, for example, is there still a lot of fruit on the nearby trees? Maybe this is because there are mines laid between the safe path and the fruit trees. People travelling together through potentially mined areas should walk in single file directly in the middle of the path and with at least a metre separating one person from the next, because mines are commonly laid on the side of the path.

- Stay well within the safe path.
- Do not walk along the edge or at the side of the path.

**Avoid Areas Likely to Contain Mines and UXO**

Some areas are more likely to be mined than are others. Avoid areas where fighting has taken place, and avoid strategic military locations, including areas fenced off by the military and areas around abandoned military camps.

**Be especially careful near these areas:**

- Abandoned military outposts, checkpoints and trenches or ditches.
- Areas containing significant physical infrastructure.
- Ruins or overgrown areas or places that show no signs of people having entered there for a long time.
- Deserted villages.
- Military bases, high security locations, potential military targets.
- Warehouses.
- Cave entrances.
- Bridges and surrounding areas.
- Naturally shady areas.
• Water sources, wells, riverbanks.

Be able to recognise warning signs

Normally the person who lays a landmine does not leave a clear sign to indicate the presence of the mine, but someone else may leave a temporary sign as a warning to others of the danger. People should be aware of the most common types of warning signs used in the areas in which they live and work. It is important, however, to note and to emphasise the fact that, if there is no clear warning sign, this should not be taken to mean that an area is safe. Sometimes, for instance, people remove minefield warning signs without considering the effect on others. A plastic sign might seem a good piece of material to use in repairing a damaged roof; the wooden stakes of a mine warning sign might appear ideal for starting a cooking fire; metal signs can easily be fashioned into buckets to carry water, and someone might simply like to have a skull and crossbones hanging before the front door. (Some people believe that a skull and crossbones can ward off evil spirits). Children, but also adults, need to be told not to remove mine warning signs, and they need to be told why this is so important.

• Be aware of the usual form of warning signs.

• If you see any warning signs, you must assume that the area is a mined area. You must go back the way you came and find an alternative, safer route.

• Do not remove mine warning signs from the area.

• If there is no warning sign, do not assume that the area is safe.

Be able to recognise warning clues

Usually mined areas do not seem particularly different from areas that are free of mines. Mines are difficult to see. They may be buried, or they may be concealed behind trees or in tall grass. However, there may be clues indicating that there are landmines in an area. The clues may be quite obvious, such as a mine exposed by the weather, or the presence of the skeletons of humans or animals. The clues may also be subtle, like a slight change in the vegetation growth pattern, a small mound, or a slight settling of the earth. If one sees anything that might be a warning clue, one should assume that the area is mined, go back and find an alternative, safer route.

The following are mine warning clues:

• Injured or dead animals.

• A partly exposed mine.

• An intact or broken tripwire.

• A fuse sticking out of the ground or lying on the ground.

• A mine packing box or mine wrapping paper on the ground.

• Discarded mine safety pins or detonator keys on the ground.

• An unusual change in the vegetation, an unusual mound, or a small hollow caused by shifting sand or settling soil.

• Signs of fighting, such as bomb craters, shrapnel lying about, or bullet casings.

• A lack of signs of the recent passage of people.

• If you do not see any warning clues, do not assume that the area is safe.
What to do if You Come Across a Landmine/UXO?

Mark and report

It should be explained to children, but also to adults, that, if they come across a mine or UXO, they should report the location to the government authorities, parents, teachers, village leaders, police, army personnel, or the nearest mine clearance unit. Some programmes advise people to mark a mine so as to warn others of the danger. It has also been argued, however, that such a marking effort may be dangerous, since one must find and place a suitable marker and therefore remain in the area of the mine and perhaps of other mines. Moreover, it may not be clear to others where the mine is in relation to the marker.

If the decision is taken to recommend marking, technical experts should be consulted, and people must be shown the proper procedures through practical exercises and not simply through the mass media or media presentations. People must be instructed about the best ways to make temporary warning signs. They must be warned not to leave a safe path in order to collect grass or sticks to make the temporary warning sign. Any makeshift sign should be recognisable as a mine warning even to children. It should also be large enough to be readily visible and sturdy enough to withstand the weather or disturbance by animals. The sign should not be placed on mined ground. People must be told not to mark individual mines, but to leave behind a clear indication within a safe area which can then be used later by mine clearance professionals and may serve as a warning for those who travel that path later not to enter that area.

• Report the location of the minefield to the authorities.

If the decision is taken to recommend marking, technical experts must be consulted, and proper marking procedures must be taught using practical exercises and not simply media techniques.

• Make the signs clear and recognisable to all.
• Do not go off a safe path to collect materials to make the sign.
• Make the signs durable enough so that they can withstand the elements

Getting Out of a Minefield

If an individual spots a warning clue (for example, an exposed mine or a hole where a mine has exploded), then the individual should assume he or she is in a minefield. The best solution is to stand still, call out for help and wait until help arrives. It has been said that “It is better to spend two days in a minefield than a lifetime as an amputee.”

Anyone finding himself or herself in a minefield must:

• Stop walking immediately.
• Warn others who may be at hand by shouting, “Stop walking! There are mines!”
• Call out for help.
• Wait for help.
• Take no unnecessary risks.

Retrace One’s Footsteps

To retrace one’s footsteps is generally not a safe option for getting out of a minefield as it is highly unlikely that the true outline of your footprint will be visible unless you are walking in mud or snow. Retracing one’s footsteps is not a safe option; it is an extremely dangerous method. Technical experts must be consulted, and proper procedures must be taught through practical exercises and not simply through media techniques if the decision is taken to recommend retracing one’s footsteps.

• Stop walking.
• Warn others nearby of the danger.
• If you cannot see the impressions of your footsteps, wait for help.

If the decision is taken to recommend retracing one’s footsteps, technical experts must be consulted, and proper procedures must be taught through practical exercises and not simply through media techniques.

• Retrace your footsteps only if you can see them clearly.
• If you retrace your footsteps, keep an eye out for exposed mines, natural disturbances or other warning clues.

• Retrace your footsteps all the way back to a sure safe path.

Rescue Procedures

Prodding

Prodding is an extremely risky mine−discovery technique. Because prodding is difficult and dangerous and requires substantial practice, it should never be proposed as a solution through a public awareness component of a mine/UXO awareness campaign.

If the decision is taken to recommend prodding, technical experts must be consulted, and the procedure must be taught using practical exercises and not simply via the mass media. Prodding should only be used if there are no other options available, for example:

• If you are in a mined area and cannot retrace your steps.

• If someone who does not know the proper procedures (for example, a child) is in a minefield and cannot get to a safe path any other way.

• If an individual has been injured and cannot get out of a minefield.

The aim is to prod the ground for mines so as to avoid them and reach a safe path. If the procedure is being used to retrieve an injured person, it is recommended that the path be wide enough to allow the rescuer to carry the injured person out of the mined area. In this case, it is not recommended that only the impressions of footsteps be prodded.

Experts should explain the technique only through demonstrations and practical exercises and until they are satisfied that the individuals being instructed are capable of using the technique properly. It is recommended that this procedure be taught to small groups and that each group member undergo individual practice sessions. Training must be carried out away from children. Mine/UXO awareness staff should be taught the procedure by technical staff until they are sufficiently proficient to pass the procedure on to others, and regular refresher training courses must be undertaken.

Chapter 6 – Annex 2: Feasibility Study and Needs Assessment *

* From the International Guidelines for Landmine and Uxeploled Ordnance Awareness Education, Section 1 and 2.

Introduction

A feasibility study can help to determine whether a mine/UXO awareness programme is required, whether it can be integrated within overall mine action and whether a particular agency, body, or organisation is well placed to undertake the effort. In particular, the study should seek to offer a preliminary overview of the extent of the threat, including the location and size of the areas affected, the severity of the impact on the population, the scope of existing mine action initiatives, and the need and urgency for additional programmatic responses. Inquiries should also help to define the purpose and focus of field visits, including the formulation of research questions to guide information collection.
Sources of Information

Sources of relevant information include:

- Official records: population figures, mine maps, accident data.
- Level One Survey Information.
- Contact with key informants, such as military, religious and political leaders.
- Contact with authorities and agencies, for example government ministries, mine action agencies, UN agencies, non-governmental organisations, agencies involved in other humanitarian sectors, and community leaders.
- Media reports, books and documents produced on the mine situation and its impact.
- Information from informal sources, such as village leaders or women’s groups.

The Need for a Mine/UXO Awareness Education Programme

Historically, mine/UXO awareness education programmes have been set up in response either to the fact that there is a high number of mine victims in a particular country, or the perception that population movements may lead to casualties due to mines or unexploded ordnance. By looking more specifically at the causes of mine incidents, one can see more clearly the ways in which injuries or deaths due to mines or unexploded ordnance can be prevented and the role, if any, a mine/UXO awareness programme might play.

Capacity Assessment

Since mine/UXO awareness initiatives seek to change risk-taking behaviour, they are rarely short-term projects. Moreover, an initiative that is poorly executed is not only ineffectual, but can also be dangerous. It is therefore essential to consider whether available agencies, organisations, or networks are capable of undertaking and maintaining a programme until the programme is handed over, incorporated into national mine action plans, or phased out.

In particular, the following questions should be considered:

- Does the agency or organisation have the resources and the depth of knowledge and experience to launch a mine/UXO awareness programme?
- Do the field offices of the agency or organisation have sufficient staff to implement a programme?
- Will the political situation and the physical access to the affected areas permit the agency or organisation to implement the programme effectively?
- Are the resident authorities supportive and is the current political climate favourable for such an initiative?
- How long is funding likely to be available?
- Is the partner able and willing to commit to the programme over the long term?
- Do any operational constraints hinder the effectiveness of the partner?
- Are other potential partners more suitable? Should more than one be approached?
The Decision to Proceed

Before any organisation or body takes the decision to initiate a mine/UXO awareness programme, it must consider operational realities carefully. In most contexts, mine/UXO awareness campaigns must be run for a number of years before there can be a chance of success. The needs of a population at risk can rarely be met through hastily conceived and implemented projects. The Feasibility Study may make it evident that the extent of the mine threat is not sufficient to require a mine/UXO awareness programme. Alternatively, existing circumstances (for instance, security, the intensity or nature of ongoing conflicts, population displacement, staffing) may make a programme impossible or impracticable. If, however, it is decided that a programme is both warranted and feasible, a detailed needs assessment should certainly be undertaken.

International Guidelines for Landmine and Unexploded Ordnance Awareness Education

Section Two: Needs Assessment

Introduction

Needs assessment is the systematic collection and analysis of information that can help to identify more precisely the populations at risk, the extent of the risk and the appropriate mine/UXO awareness strategy. The cornerstone of the assessment is data-gathering and analysis. Indeed, the systematic gathering and analysis of relevant data are central to the successful development of all stages of a mine/UXO awareness programme. What is important here is a judicious identification of the questions and a determination of the level of accuracy of the answers. This information will be invaluable in defining mine and UXO awareness strategies.

As far as possible data should be gathered continuously throughout the programme implementation starting with the collection of baseline data. The scope and the depth of the needs assessment depend on the financial and logistical resources available to the implementing organisation, as well as on the types of information required of the assessment.

Coordination

Coordination among all stakeholders provides a basis for the proper management of the needs assessment and helps avoid the unnecessary duplication of effort. Data collection can represent an opportunity for intensive training that sets the stage for all subsequent interventions. It requires focus, commitment, enabling resources, and foresight so as to ensure that the methodology is reliable and representative of the population under study and that it provides a baseline to build upon and for comparison with subsequent efforts.

The data to be collected

The programme design issues which the assessment must address are:

- What is the magnitude and geographic focus of the problem?
- Who is affected and therefore who should be targetted?
- How are people affected – physically, psychosocially, economically?
- What is likely to induce behaviour change, and who will be most likely to alter their behaviour?
- What are the circumstances in which people are injured?
- What leads to risk–taking behaviour (which would need to be addressed in the education campaign)?
• What are the ways in which people communicate and learn?
• What is the treatment or response provided and how appropriate is this?

Statistics about Victims

Current statistics on landmine-related injuries are often based on extrapolations from partial survey information. Data on landmine-related injuries and disabilities are difficult to collect because the regions most affected by mines are generally among the poorest and most inaccessible, and are sometimes at war. Understanding the magnitude of landmine-related injuries is crucial for the development of appropriate interventions, impact evaluation, and optimal use of resources. Demographic information such as age, gender and occupation of mine victims and survivors is needed to determine the characteristics of those being killed and injured and which group to target for preventive action. An individual’s specific activity at the time of injury and location where the injury took place are necessary to determine how and where these injuries are happening. To show the responses required to manage these injuries and to prevent disability, information is needed about the type of treatment provided, the duration of hospitalisation, the outcome of the accident\(^1\), the type of rehabilitation, the type of prosthesis and the duration and outcome of rehabilitation.

\(^1\) Outcome refers to deaths and injuries (including permanent disability incurred during the accident) and should be added to the list of data to collect.

Mine/UXO awareness education programmes should rarely seek to target an entire community through a single approach, since the factors that affect the adoption of safe behaviour vary greatly from individual to individual, group to group, and community to community in terms of:

- The age of victims
- The gender of victims
- The status of victims:
  - Civilian
  - Combatant
  - Refugees
  - Internally displaced
  - Settled rural community
  - Urban population
  - Specific rural population (nomads, seasonal migrant, etc.)
- The activity of victims at the time of the mine accident
- The location of accidents
- The date of accidents
- The types of areas mined

Other information can help determine the level of the risk to populations. For instance, the number of refugee mine victims in countries of asylum where no mine victims have yet been recorded might serve as an indicator of the mine threat in the country from which the refugees have fled.

Reasons for Mine/UXO Accidents

The following are examples, not in any order of hierarchy, of the most persistent causes of mine accidents.

- A lack of knowledge about mines/UXO or the threat they pose.
- Economic necessity or survival imperatives: Many mine/UXO incidents occur because of deliberate decisions made by individuals or communities. Individuals or communities may believe that the perceived benefits of preventive action outweigh the perceived costs of such action. An individual might try to extract the aluminium component of UXO and sell it for much-needed income. Another might wish to collect firewood in a mined area to use for cooking or heating.
• Previously cleared areas have been re‐mined.

• Sudden environmental changes, such as flooding, can cause mines to become freshly exposed or shift the position of mines.

• The recklessness engendered by familiarity among individuals exposed to mines or UXO over long periods.

• Inaccurate or misleading information about mines or mined areas.

• Religious and cultural convictions favouring fatalism, or a belief in magic or in the power of karma. In some societies, people wear amulets in the expectation that the amulets will protect them from injury in minefields.

• Belief in one’s own invincibility. For example, people who have survived a long and bitter armed conflict may come to think that mines cannot harm them.

• Behaviour consistent with one’s self‐image. For instance, men may be reluctant to report the presence of UXO to mine clearance teams, as this might be taken as a sign of their weakness or incapacity.

• Curiosity can affect behaviour, particularly among children. Being told about the dangers of mines/UXO may even stimulate an individual’s curiosity to find out more. What will happen if the mine is touched? Or hit with a stone? Will it really explode?

• An individual may come under direct or indirect pressure from relatives, peers, friends, or other community members not to adopt safe behaviour. For example, peer group pressure may lead a boy to attempt to prove his courage by entering a minefield.

• Any mixture of factors.

The Context for Mine/UXO Awareness

Other factors for which data are needed in order to implement an effective programme include:

• The types of mines and UXO and the most common types of mines, UXO and booby‐traps.

• The location of mines and the types of land affected.

• The existing infrastructure.

• Population statistics, including: size, demographic make‐up, sub‐groups.

• The roles of men, women, children, various ethnic groups, community leaders and influential community members; power structures.

• The level of education, including literacy rates.

• The political context.

• The historical context, including the history of the conflict.

• The national plan for mine action, as well as the nature of mine action initiatives.

• The situation in the country in terms of the existence of a humanitarian emergency, a conflict, a post‐conflict environment, the level of development, and so on.

• The resources available locally, including in those areas in which the mine/UXO awareness programme should take place and through agencies and organisations in terms of funding, personnel, training, logistics.
• Communication channels, including:
  • Languages, dialects, oral traditions, traditional media
  • Traditional systems of education
  • Materials and communication methods familiar to the population

• The lessons learned through mine/UXO awareness initiatives in the country.
• The lessons learned through mine/UXO awareness initiatives in other countries.
• The lessons learned through other emergency or development programmes in the country, for example, education and public health initiatives.
• The local coping strategies for dealing with the mine problem.

Information Sources

Where mine survey activities have been undertaken, information will already have been deposited with the national Mine Action Centre (MAC) or its national equivalent. Level One Survey will provide general data on the extent and impact of landmine and UXO contamination on a community. Level Two Survey provides more detailed information on the extent of mine contamination, and aims to delineate the perimeter of mined areas. It will also normally provide more specific information on the types of mines and UXO found in the area. Level Three Survey, conducted in conjunction with mine clearance, accurately records the area cleared. Mine/UXO awareness programmes will need to refer regularly to the information available as a result of the survey activity, and orient the programme accordingly. However, the more specific information needed for mine/UXO awareness planning may still need to be collected. Since records are often incomplete, information may have to be collected at a variety of levels (community, district, national), and in particular from hospitals, humanitarian agencies and organisations, government departments, and local authorities.

a) Information Sources at the Community Level

The school system, the health care system and local community leaders can all be used as sources for an ongoing information flow and for monitoring. Village-level data gathering leads to a better understanding of the needs of a community as perceived by the community. Throughout, feedback must be provided to the community, as the community is unlikely to participate extensively if it does not receive any tangible benefit.

b) Information Sources at the District Level

Trends in accident statistics, prosthetics treatment and travel time for care after major trauma can be more clearly identified at the district level, where such information is also more likely to be accurate. When carried out through an institution, district data collection tends to flow with less interruption and is representative of a wider cross-section of the population.

c) Information Sources at the National Level

National data gathering occurs primarily in cooperation with ministries of health, social welfare and planning and the national Mine Action Centres (MACs) or its national equivalent. The data are often more technical and sophisticated as regards, for example, the number of artificial limbs fitted each year. The collection of data at this level may also boost mine/UXO awareness among national authorities. In contrast, there may be some unwillingness to release information that is considered sensitive.

Methodologies

The choice of methodologies must be based on the following:

• Questions to be answered by programme designers
• A review of existing information and identification of corresponding information gaps
The level of precision required for the answers to each question, for example, is a qualitative assessment adequate, are service-based data adequate or are representative statistics required.

The scope of each question, i.e. does it refer to conditions nationally, sub-nationally, locally, and/or for a particular sub-group and therefore the coverage of data collection and sampling required.

Resources available for the assessments (human resources such as number and skill levels, financial resources, logistics support)

Accessibility and security

The range of sources include government offices, hospitals, humanitarian organisations, local authorities, and communities. The range of methods for gathering qualitative and quantitative data, including surveys, community meetings, interviews, reviews of existing records, and personal observation.

The proper design of qualitative and quantitative data collection and analysis of data requires some technical expertise and knowledge of the use and limitations of the different methods.

Resources on qualitative data collection include the following:


Resources on quantitative data collection include the following:


a) Sampling

In order to put the information collected into context, one must obtain feedback from a sample group that is truly representative in terms of size and characteristics. The appropriate size of the sample group varies depending on the total number of beneficiaries. In general, mine/UXO awareness campaigns target individuals living close to land contaminated by mines, people planning to travel into or through contaminated areas and people, such as children, tending to display high-risk behaviour around mines. The number of such people is often relatively large. A rule of thumb for the size of the sample is that around 5 per cent of the target audience in a given area should be included. One should be careful to select those people that may be most representative of high-risk behaviour (this obviously depends on the overall number of beneficiaries and is suggested for smaller total audiences only).

An appropriate simple sampling method based on questionnaires involves the use of “stage clusters”. From a list of all of the villages in the target area choose a number of clusters. This is the first stage of cluster sampling. It should cover approximately 5 per cent of the total audience. Randomly select from this cluster the first household from which information is to be gathered; thereafter, continue sampling the nearest households until the sample number is reached. The results of such a survey should be adequate for decision-making purposes at the community level.

b) Designing Questionnaires

A key method for monitoring and evaluating mine/UXO awareness programmes has been to rely on questionnaires. Questionnaires are generally used to obtain information in a guided fashion. They may be
structured (employing "closed" questions, e.g., “Have you received mine/UXO awareness instruction?”) or semi–structured (open–ended questions, e.g., “What would you do if you found a mine?”). Questions should be phrased so as to measure skills, knowledge, attitudes, and behavioural change. A questionnaire should be easy to complete (preferably one page in length) and should therefore take only a few minutes to fill out properly. Completing it should not require a substantial amount of education or training, since the interviewer and the interviewee may have only marginal reading and writing skills. Questions should:

- Be easy to understand
- Be culturally sensitive and specific
- Not prejudice the response

c) **Pre–testing**

It is vital that the questionnaire and the interview methodology be pre–tested if programme planners are to ensure that the intended information is obtained and that the respondents truly understand the questions being asked. The interviewers must be trained to observe, ask questions and record information according to a predetermined, standard pattern. If the questionnaire is to be translated, care should be taken to translate the questions accurately. (One way to check is to ask a third person to translate the questions back into the original language.)

d) **Carrying out interviews**

It is important to seek the permission of the respondent before carrying out the interview. It is likewise important to declare the purpose for which the interview information is being collected, to identify the agency responsible for authorising the interview process (for instance, is it sanctioned by the local military authorities?), and to explain that the identity of the interviewee will remain strictly confidential. One should endeavour to start the interview process with the least contentious questions so as to build confidence between the interviewer and the interviewee (whether questions are controversial or not, depends on culture to a certain extent).

**Information Management**

It is important to establish early on a proper database for the storage and analysis of the data generated. The national Mine Action Centre or national equivalent will maintain a database which will record information on all aspects of the mine action programme. Ideally, the mine awareness database should be a component of this database. However, if it is separately held, there must be coordination to make sure that the databases can exchange information. Database software that can handle the relatively meagre data needs of a mine/UXO awareness project is readily available. Individuals must be trained for the data entry effort so that they can avoid duplication and data entry errors and so that the overall maintenance of the database is guaranteed. These individuals should also be sufficiently familiar with the software in order to perform the analysis and reporting functions. Data entry requires a relatively unskilled person, whereas data analysis requires a highly skilled person. Reporting routines should be carried out internally on a regular basis and externally as required by outside agencies and other mine action organisations.

It is recommended to contact the national Mine Action Centres for information on standardized formats and procedures to collect information on mine action in general and mine/UXO awareness education in particular. Examples of standardized formats and procedures to collect information on mine action are multi–disciplinary assessment missions and national (Level One) surveys. Assessment missions and national surveys are key components of the overall information management process which was established in 1998 with the aim of harmonising the collection and dissemination of information on mine action. An important tool in this process is the Field Module of the Information Management System (IMSMA), which is employed within national National Mine Action Centres and contains standardised formats for information reporting.

**Training and the Commitment of Resources**

A specific commitment to the collection and analysis of data requires a corresponding commitment of resources in terms of personnel, equipment and training. If mine action initiatives are to become integrated, interactive and mutually supportive and if an isolationist and fragmented approach is to be avoided, then the
managers and team leaders involved in the various activities need to be familiar with:

- The importance of information to the programme
- The various methods for getting the information
- The way to use the collated and analysed information
- The activities of the components in a national mine action programme and the activities of the relief and development sectors

**Information Analysis**

It is essential not only to collect data, but also to analyse data. In the absence of expertise, personnel and the time to collect, interpret and analyse information, data collection is of little value. Analysis should include the identification of additional information needs for planning and monitoring.

Information analysis determines the quality of information which include precision, coverage/representativity, potential bias, and therefore places limits on conclusions. In spite of this, conclusions must be drawn carefully and their implications assessed, identifying areas for further data collection.

A mine/UXO awareness programme can only intervene effectively if the reasons for high-risk behaviour have been clearly understood. It is possible to distil these reasons into three main categories:

- a) People are aware of mines and know how to minimise the risks of mines, but they persist in high-risk behaviours. Factors other than awareness and knowledge can affect behaviour, including attitudes, social pressures and economic necessity.
- b) People do not know the safest behaviour to practise around mines. They may be aware of mines, but may not have the appropriate knowledge or skills to reduce the risk mines pose.
- c) People are not aware of mines. They may be unaware of the existence of mines or of the dangers of mines.

Mine/UXO awareness strategies have largely focused on the prevention of incidents caused by a lack of awareness of mines or a lack of knowledge of safe behaviour. Very few programmes have sought to prevent the injuries and deaths that can result from conscious high-risk behaviour, even though it is believed that this accounts for the bulk of mine incidents in many contexts.

**The Result of the Needs Assessment**

The analysis of the information gathered during the needs assessment will be invaluable in determining the strategy to be adopted for the future mine and/or UXO awareness programme. The combination of quantitative and qualitative information contained in the analysis will ensure that programme planners have a firm basis on which to work.

**Chapter 7: Protecting the Rights of the Child**

**Rationale**

Children living in countries in armed conflict are among the most vulnerable in the world. The nature of armed conflict, and the humanitarian crises and breakdown of society that results, creates new rights violations and exacerbates existing ones. Children suffer from violations of their rights – to life, to health, to education, to an adequate standard of living, to protection from abuse, exploitation, neglect, oppression, discrimination and recruitment into the military. Girls are particularly vulnerable because of the prevalence of sexual abuse, including rape.
Many vulnerable children are living in areas characterized by a breakdown of political institutions, social and economic infrastructure, essential services, and legal and judicial systems, where the sovereign government may no longer even control the area where the child lives. Civil society and its institutions are frequently so oppressed and disempowered that their capacity to defend the rights of their own children is seriously weakened. And, perhaps most critically, the breakdown of communities and households through death, displacement, disease and loss of economic capacity disables the most important layer of care and the protection of the child.

The commitment to promote the survival, protection and development of children has existed as part of UNICEF's fundamental mandate for many years. However, conditions today are often so extreme and abusive for children that their well-being can only be assured through a stronger and more consistent approach to protecting them from harm and to promoting their rights.

General Aims and Strategies

**General Aim**

UNICEF's child protection actions in the context of armed conflict and other emergencies aim to:

- protect children from harm inflicted by others (exploitation, abuse, neglect, cruel and degrading treatment, recruitment, etc.);
- protect the integrity of humanitarian assistance through ensuring access to all in need.

"The protection of children means ensuring respect and fulfillment of their rights as expressed in the Convention on the Rights of the Child, in other international human rights instruments and international humanitarian law. Responsibility for ensuring such protection belongs to those with control and influence over children – first and foremost their families and communities as well as their Governments, de facto authorities and other institutions or organizations. Such protection aims particularly to prevent all forms of violence, exploitation, abuse and neglect of children. Protection, so defined, involves the practical implementation of human rights and humanitarian law on behalf of children. It involves both the adoption and enforcement of legal norms and ensuring respect for the fundamental ethical principles reflected by those norms even in places where there is no formal legal system to enforce them."

According to the State of the World's Children, it is estimated that in the last decade child victims of conflict have included:

- 2 million killed;
- 4–5 million disabled;
- 12 million left homeless;
- more than 1 million orphaned or separated from their parents;
- some 10 million psychologically traumatized.

Protection actions seek to protect children from both the direct impact of armed conflict and from other forms of exploitation and abuse – e.g. sexual, economic slavery, discrimination – that may have pre-dated and continued or even worsened during the conflict.

Supporting strategies include:

- ensuring the commitment of the political authorities – governments or non-State entities – to the promotion of international standards of humanitarian and human rights law;
- increasing the awareness of the local authorities and the population at all levels of society protection instruments (especially the CRC and international humanitarian law);
- establishing a capacity to monitor, document and respond to violations of humanitarian principles;
- ensuring that child rights are the basis of all UNICEF activities, whether for service delivery or 'protection';
• promoting the involvement of local institutions and civil society through capacity-building and the creation of alliances;

• ensuring linkages with traditional values and practices.

Basic Principles

UNICEF also believes that obligations and responsibilities to the citizens of a country should be upheld by non-State parties as well as sovereign governments. Some of these international standards of child protection are explained in more detail below. All UNICEF offices should have complete copies of these documents accessible to all staff in appropriate languages.

Constitution on the Rights of the Child

Basic Principles

The legal and ethical values and basic principles that underpin UNICEF’s protection work lie in the international standards found in the Convention on the Rights of the Child and other relevant human rights legislation, including:

• the 1966 Covenant on Civil and Political Rights
• the 1966 Covenant on Economic, Social and Cultural Rights
• CERD (Convention on the Elimination of All Forms of Racial Discrimination), 1965
• CEDAW (Convention on the Elimination of Discrimination Against Women), 1979
• CAT (Convention Against Torture), 1984
• The Convention on the Prevention and Punishment of Genocide, 1949
• the 1951 Convention Relating to the Status of Refugees and the 1967 Protocol
• Domestic legislation
• The 1949 Geneva Conventions and Additional Protocols (1977)
• Internationally recognized humanitarian principles

A comprehensive understanding of and compliance with the CRC must be central to all UNICEF activities. Summaries of the following articles are included here as they are likely to be central to much of UNICEF’s protection work in conflict areas:

• Article 2, Non–Discrimination: All rights apply to all children without exception. It is the State’s obligation to protect children from any form of discrimination and to take positive action to promote their rights.

• Article 3, Best Interests of the Child: All actions concerning the child shall take full account of his or her best interests. The State shall provide the child with adequate care when parents, or others charged with that responsibility, fail to do so.

• Article 6, Survival and Development: Every child has the inherent right to life and the State has an obligation to ensure the child’s survival and development.

• Article 12, Participation: All children have the right to participation in decision–making processes that may be relevant in their lives and to influence decisions taken in their regard – within the family, the school or the community.

• Article 38, Armed Conflicts: States Parties shall take all feasible measures to ensure that children under 15 years of age have no direct part in hostilities. No child below 15 shall be recruited into the armed forces. States shall also ensure the protection and care of children who are affected by armed conflict as described in relevant international law.

• Article 39, Rehabilitative Care: The State has an obligation to ensure that child victims of armed conflicts, torture, neglect, maltreatment or exploitation receive appropriate treatment for their recovery and social reintegration.
International Humanitarian Law

International humanitarian law limits the methods of conducting military operations. The fundamental rules of international humanitarian law are as follows:

- Those who do not take a direct part in hostilities, are put out of action, or are disabled are entitled to respect for their lives and physical and moral integrity.

- It is forbidden to kill or to injure an enemy who surrenders or who isn’t participating in hostilities.

- The wounded and the sick shall be collected and cared for by the party to the conflict that has them in its power. Protection also covers medical personnel, establishments, transports and supplies. The emblem of the Red Cross is the sign of such protection and must be respected.

- Captured combatants and civilians are entitled to respect for their lives, dignity, personal rights and convictions. They shall be protected against all acts of violence. They shall have the right to correspond with their families and to receive relief.

- Everyone shall be entitled to fundamental justice. No one shall be held responsible for an act he or she has not committed or be subjected to physical or mental torture, corporal punishment, or cruel or degrading treatment.

- Parties to a conflict should not have an unlimited choice of methods and means of warfare that cause unnecessary losses or excessive suffering.

- Parties to a conflict shall spare civilian populations and property. Attacks shall be directed solely against military objectives.

Humanitarian Principles

Optional Protocol

UNICEF supports the Optional Protocol to the CRC and advocates for the complete prohibition of children below 18 years in armed conflict.

Adopted without a vote by the General Assembly on May 25, 2000, the new Protocol on the Involvement of Children in Armed Conflict states that:

Article 1: States Parties shall take all feasible measures to ensure that members of their armed forces who have not attained the age of 18 years do not take a direct part in hostilities.

Article 2: States Parties shall ensure that persons who have not attained the age of 18 years are not compulsorily recruited into their armed forces.

Article 3.3: States Parties that permit voluntary recruitment into their national armed forces under the age of 18 shall maintain safeguards to ensure, as a minimum, that:

a. Such recruitment is genuinely voluntary;

b. Such recruitment is done with the informed consent of the person’s parents or legal guardians;

c. Such persons are fully informed of the duties involved in such military service;

d. Such persons provide reliable proof of age prior to acceptance into national military service.
Article 4.1: Armed groups that are distinct from the armed forces of a State should not, under any circumstances, recruit or use in hostilities persons under the age of 18 years.

The following are internationally recognized humanitarian principles.

**Humanitarian access**: Humanitarian assistance must be provided to all civilians in need, independent of political or military considerations. The parties to the conflict accept that humanitarian assistance to civilians must be granted free passage at all times to humanitarian staff. Denial of access to a specific location or area shall be exceptional and justified. In any event, consultations shall be undertaken with the aim of restoring access as soon as conditions permit, so as to avoid prolonged disruption of relief operations.

**Neutrality**: Humanitarian agencies must not affiliate themselves to any side of the ongoing conflict, nor must they interfere in the conflict. Aid must not be used to advance any political, religious or ideological agenda.

**Impartiality**: Humanitarian aid must be given according to human need alone. Resources and practicality should be the only limits in responding to humanitarian needs.

**Humanitarian assistance is solely for intended civilians**: In accordance with the principle of neutrality, diversion of aid from intended beneficiaries is a breach of humanitarian principles and such aid should be returned.

**Humanitarian programmes should be accountable for their operations to those whom they serve as well as to those who fund their activities**: Those providing assistance have a duty to ensure that aid reaches its intended beneficiaries in the most effective and efficient way possible.

**The security of humanitarian staff and material resources shall be respected in all situations**: Relief staff, whether expatriate or local, working under the auspices of a humanitarian programme shall enjoy the protection due them in their humanitarian endeavours.

**Respect for international humanitarian law and human rights**: All involved in a conflict must respect international humanitarian law and fundamental human rights, particularly the rights of children as enshrined in the Convention on the Rights of the Child.

**Refugee Law**

The fundamental principle of refugee protection is that of *non-refoulement* which prohibits the return of a refugee to a territory where he or she may be persecuted. This right is contained in Article 33 of the 1951 Convention Relating to the Status of Refugees:

“No Contracting State shall expel or return (“refouler”) a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion.”

**Protection of the Internally Displaced**

Unlike refugees, those who have fled their homes but have not crossed an international border are not protected by a special agency or by a special body of law. Their situation is often much more vulnerable, particularly when they are living in areas controlled by rebel movements or where – by virtue of their race, religion or political affiliation – they are considered the ‘enemy’. Protection of internally displaced persons should be guaranteed by national legislation concerning the rights and well-being of all citizens, international human rights obligations of governments and, in cases of armed conflict, by international humanitarian law (see Annexes 6 and 7).

**Programme Strategies and Actions**

The following section outlines UNICEF’s child protection response in situations of armed conflict and other emergencies. The precise mix of actions should be determined by need and the complementary capacities of
UNICEF and its partners in the country in question.

**Political Sensitivity and Safety**

It cannot be over-emphasized that active promotion of child rights is very politically sensitive particularly in situations of conflict. UNICEF Representatives and staff must, at all times, take into account the security of staff, particularly national staff who may be considered part of the ‘enemy’ by any party to the conflict.

**Advocacy and awareness-raising**

When possible, an active and assertive advocacy and awareness-raising campaign of humanitarian laws and principles is essential as a first step in all child protection efforts. Although specific messages will depend upon the particular priorities of the emergency, the following basic messages are likely to lie at the heart of most advocacy and information programmes:

- the child’s right to life;
- the right to humanitarian assistance including food, health care, education, basic services (water and sanitation, shelter, etc.);
- the right to protection under international humanitarian law especially:
  - distinction between military and civilians
  - protection of civilians and their property (no killing, looting, cruel or degrading treatment)
  - protection of essential services (health centres, schools, churches)
  - no denial of access to humanitarian assistance and protection of relief workers;
- neutrality and impartiality of humanitarian assistance (no account to be taken of political or ethnic considerations);
- special care and protection for children without families or in situations of deprivation or distress, and physical and psychological rehabilitation and social reintegration;
- no recruitment of children under the age of 18 into the armed forces;
- protection from sexual violence and abuse.

Advocacy and/or awareness-raising efforts should be aimed at the worst perpetrators of violations of child rights as well as at those most likely to assist in preventing or advocating against these violations – the military, journalists, lawyers, international relief staff, officials of governments and non-State parties, officials of local NGOs, religious leaders and activists, traditional chiefs, women’s leaders, police, and others influential in society.

Where possible, dissemination should be done by nationals of the country and be linked to local traditional values of care and protection for the child. During armed conflict, such protective values often break down as a result of violence, fear, economic stress, and the disintegration of communities and legal systems; but they still provide an important reference point for the principles of the CRC and the Geneva Conventions. The CRC and other relevant instruments should be translated into local languages and distributed as part of the advocacy and dissemination campaign.

**Ensuring written commitments**

Responsibility for humanitarian diplomacy and advocacy lies with the OCHA coordinator, who ensures that the protection of children and their rights is central to all written agreements between humanitarian agencies and all parties to the conflict. UNICEF, can however, play an important role.

Written commitments are particularly important when working with rebel movements, and their families living outside of government control. It is essential that the de facto authorities in such areas, make formal written commitments, at the highest level, to the above-mentioned principles and to the protection of children and other civilians.

**Protection Strategies**

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Monitoring violations

The monitoring and reporting of violations of child rights must be handled with great diplomacy and tact. UNICEF’s actual role will depend on the problems, needs and capacities of other organizations working in the area. UNICEF has a role, even in times of conflict, to assist in the preparation of periodic reports on adherence to the Convention. This should begin with identifying areas of legislation that do not conform to the standards of the CRC. UNICEF should seek to work with governments, other UN agencies, local NGOs, and other groups involved in child and human rights. In areas under the control of non-State entities, UNICEF should also seek to monitor adherence, particularly after a formal commitment has been made to the CRC.

Although international human rights organizations such as Amnesty International, Human Rights Watch and others may issue periodic reports on human rights abuses, where no such other organization is involved, UNICEF must ensure that, at the very least, by bearing witness it does not allow the children who have been abused to suffer or even to die forgotten.

Reporting

How UNICEF uses information on violations of child rights will depend upon the delicacy of the political situation, security concerns and local, national or international opinion. At all times, UNICEF must be true to its mandate to promote the rights of children. Options for UNICEF include the following:

Confidentially raising the violations to the appropriate political authority: Confidential reporting is part of a more general policy of constructive engagement and quiet diplomacy through seeking dialogue and consensus. This does not create a public battle with the party concerned and therefore makes it more possible for UNICEF to continue with its care and protection roles. However, sometimes it does not lead to the kind of public pressure that motivates governments or rebel forces to respond.

Bearing Witness

Although international human rights organizations such as Amnesty International, Human Rights Watch and others may issue periodic reports on human rights abuses, where no such other organization is involved, UNICEF must ensure that, at the very least, by bearing witness it does not allow the children who have been abused to suffer or even to die forgotten.

Reporting to the Committee on the Rights of the Child: Governments must report on their adherence to the Convention on the Rights of the Child two years after ratification and every five years thereafter. Although the Committee has an important role, it does not have the speed of response to follow up effectively on reports of violations or the capacity to deal with violations by non-signatories.

Making public criticisms: This is a measure that has to be taken with utmost caution because of the impact on programme delivery or the security of staff. The issue of public disclosure and criticism is complex, sensitive and fraught with moral ambiguities. UNICEF policy does not yet fully address the conflict between a position that might jeopardize its programmes or staff, and risking colluding with flagrant violations of child rights. The following criteria should be a used to judge when public criticism is justified and likely to be useful:

• the action was witnessed by UNICEF staff or the evidence is extremely reliable;
• such actions have been repeatedly carried out by those responsible;
• previous attempts at confidential reporting have yielded no results;
• public criticism is in the best interests of the victims of these violations.

There will not be any serious repercussions against victims, agencies delivering services or the public.
Passing information confidentially to human rights groups or the media: In cases where UNICEF does not feel able to make public statements on violations, it can provide information confidentially to organizations that are able to make the information public, normally either human rights groups or the media.

Where UNICEF is involved in the direct monitoring and reporting of violations, the following problems should be noted:

Lack of access to areas where violation has occurred: The success of fact-finding depends on free access to the area. UNICEF should insist in its written agreements that, where possible, it has unrestricted access to children, including the monitoring programme impact and any violations.

Threats to the safety and security of monitors: Investigations should not be conducted if they pose a serious security risk to the staff members concerned. All staff involved in this work should be trained in security and negotiation skills.

Threats to the safety and security of witnesses: Those providing information about the flagrant violation of child rights may find their safety threatened. Never do anything that might compromise the safety of witnesses and always guarantee confidentiality of information. Failure to do so will compromise their lives and will discourage anybody from providing information to UNICEF or to other groups.

Creation of Safe Environments

Whenever possible, UNICEF should seek to create conditions for the improved physical protection of children and the creation of safe environments. Actions may include:

- Negotiating for universal access to children in conflict, through the offices of OCHA.

- Improving the security of camps and centres for the displaced and refugees to protect girls from gender-based violence and sexual abuse.

- In conflicts where children are active participants in the military, challenging military and civil authorities to demobilize those under 18 years of age, and supporting demobilization through alternative training, education and psychosocial assistance for the young fighters (see Panel 1).

- Where child soldiers or other children are the subject of war crime accusations, helping to develop an appropriate legal or institutional framework to consider accusations, which includes having young combatants housed in jails separate from adults as well as some basic rehabilitative services will be provided.

- Promoting periods of tranquillity and safe corridors in conflict zones through a temporary or partial cease-fire or cessation of hostilities, to allow access to children (and their families) in need; and serving as advocates for the humanitarian imperative that children’s needs should not be jeopardized by military or political considerations.

Strengthening Local Institutions for Children

UNICEF has to seek partners to find innovative ways of strengthening families and communities to better care for and protect their children. Those children who remain with their families and communities suffer much less than those separated from their primary caregivers.

The cause of child rights must be placed firmly as a responsibility of communities, institutions of civil society, governments, and non-State parties. This will require assistance to those local institutions willing to take on a leadership role in advocacy, dissemination and monitoring of child rights. Such assistance, whether technical, financial, material or political, is vital to promote a child protection strategy that goes beyond UNICEF’s, and is sustained by the country and its people.
Coordination and Partnerships

The effective protection of children in emergencies, and especially in situations of conflict, is far beyond UNICEF’s capacity acting alone. The establishment of partnerships and the identification of strategic allies should begin as early as possible – preferably in the pre–emergency phase and certainly immediately following the outbreak of a crisis. Possible partners include the following:

**UN High Commission for Refugees (UNHCR)**

The UNHCR mandate focuses primarily on refugees or those outside their country of origin who are unable or unwilling to return there owing to a well–founded fear of persecution for reasons of race, religion, nationality or political opinion. Refugees include groups who have fled man–made disasters, including armed conflict and others instances of generalized violence. UNHCR’s work involves providing international protection to refugees and finding permanent or durable solutions to their plight.

**Office of the High Commissioner for Human Rights (UNHCHR)**

In the past few years, field work has significantly increased from very few activities in a limited number of countries at the beginning of the 1990s to 27 human rights field presences, in all parts of the world, in 2000. Over the years, the legislative basis for the presence of UNHCHR on the ground has changed. Initially, it had been in response to emergency human rights situations, or as a result of action by an intergovernmental body, or following an agreement between the Office and the Government concerned. In these cases, UNHCHR field work is a combination of promotion and protection functions. Recently, however, requests for technical cooperation programmes aimed at building up or strengthening national human rights capacities or national human rights infrastructures are becoming a dynamic part of UNHCHR work on the ground. The UNHCHR field monitors are potentially very important allies for the collection of information regarding the violation of the rights of children.

**Non–governmental Organizations (NGOs)**

Most humanitarian NGOs do not have protection or human rights mandates and often do not wish to involve themselves in protection work for fear of compromising their capacity to deliver services or the security of their staff. However, there is a growing consensus that the provision of assistance cannot be separated from the protection of civilians. It is likely that more and more NGOs will start to develop strategies, policies and active programmes on the protection of civilians. Chief among NGOs potential allies are the members of the International Save the Children Alliance (ISCA), who, like UNICEF, are turning increasingly to the CRC as a basis for their activities.

**International Committee of the Red Cross (ICRC)**

ICRC’s protection role stems from its mandate under international humanitarian law to help protect civilians and other non–combatants and to prevent attacks on their moral and physical integrity and prevent their cruel and degrading treatment. It also promotes the right of access to humanitarian assistance provided for in international humanitarian law. Actions to promote the protection element of ICRC’s mandate include advocacy to promote ratification of the Geneva Conventions; dissemination of international humanitarian law negotiations with parties to the conflict to ensure humanitarian access; overseeing the practical implementation of international humanitarian law; and specific activities such as visits to prisoners of war and civilian internees.

**Office for the Coordination of Humanitarian Affairs (OCHA)**

As the coordinator of humanitarian assistance, OCHA has an important role to play as an advocate for international humanitarian standards and the rights of civilians. OCHA’s protection mandate includes the promotion of human rights, humanitarian and refugee laws, and legal institutions; diplomatic efforts to enhance the safety of vulnerable persons or groups; and providing an international presence to deter attacks and violations of human rights and humanitarian law, and/or providing a measure of confidence and security for victims.

Other local and international human rights groups, religious organizations, women’s groups and others also may be important advocates of child rights.
Further Guidance

Convention on the Rights of the Child

Geneva Conventions and Additional Protocols

UNHCR Guidelines on the Care and Protection of Women

UNHCR Guidelines on the Care and Protection of Children

Panels

Panel 1 – Identifying Priorities

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<th>IDENTIFYING PRIORITIES</th>
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<td>The following checklist suggests questions to help identify problems being faced by children and the nature of UNICEF’s response.</td>
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<tr>
<td>• What kinds of abuse, neglect and exploitation are being committed against children? Who is implicated in these incidents? Where are they occurring?</td>
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<td>• Who is gathering information on abuses? UNICEF? Other national or international organizations? What is being done with the information – is it being reported to the perpetrators? To the press? To human rights groups? How could the system be strengthened?</td>
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<td>• Do humanitarian agencies have access to all children in need? If not, why not?</td>
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<td>• Where there are communities without access to humanitarian aid, what has been done to negotiate with those in control? Are there possibilities of establishing safe corridors or days of tranquillity?</td>
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<tr>
<td>• Are there children in prison? With what crimes have they been charged? Are they being kept in jail with adults? What has been done to ensure due process?</td>
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<td>• Are children being recruited into the military? By whom and in what numbers? If so, what has been done to prevent this? To demobilize children and return them to their families?</td>
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<td>• How many children are affected in different ways by landmines?</td>
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<td>• Is ICRC carrying out dissemination of the Geneva Conventions with the military on all sides? What else is being done to educate key groups on IHL, CRC and other international standards?</td>
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<tr>
<td>• What media channels exist for the dissemination of child rights messages? Are they being used effectively?</td>
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<td>• Has there been any retaliation or threat made against any person or organization who has spoken out against violations of child rights?</td>
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Panel 2 – Implementing Child Protection

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<td>This panel lists specific country-level child protection activities to be implemented during the Emergency Phase as well as Pre– and Post–Emergency Phase.</td>
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Pre–emergency phase

Promote laws and values that embody respect for children and their rights, including dissemination of appropriate conventions and principles
Analyze national legislation to ensure that it conforms to the standards of the CRC

Support national reporting to the Committee on the Rights of the Child including the creation of monitoring systems

**Actively disseminate information** at all levels of society, including the military, to promote awareness of child rights and the need for protection, linking such dissemination to traditional values relating to the care and protection of children and to the protection of civilians in conflict

**Emergency phase**

**Promote** humanitarian principles for the neutral, impartial, accountable, and transparent delivery of humanitarian assistance and for the protection of relief supplies and humanitarian workers

**Promote** international standards (especially CRC) and national legislation that embody respect for children and women and their rights

**Promote** national and community-level dissemination of ethical principles linked to local cultural values for care and protection for the child

**Negotiate** with governments and rebel movements to gain formal commitments for CRC, the Geneva Conventions and humanitarian principles

**Strengthen** the capacity of families, communities, churches, local NGOs and others (through technical and material support) to become active partners in the promotion of child rights

**Negotiate** for the creation of safe environments for children – zones of peace, days of tranquillity, safe access corridors

**Advocate** for demobilization and rehabilitation of child fighters

**Monitor** violations of child rights commitments embodied in the CRC, the Geneva Conventions, national laws, refugee conventions and other legal instruments

**Respond** to violations of child rights through protests to those responsible, and the channelling of information to the UN Centre for Human Rights, or other measures

**Protect** children and women against sexual violence and abuse through improved physical features in camps and training of military and others

**Oppose** climates of impunity through support for international tribunals, truth commissions and other measures to ensure enforcement of law against the perpetrators of child rights violations

**Review** national legislation, rights and social status of women, girls and other children in the light of the presence or absence of real protections during the emergency period, and as the basis for advocacy of new legislation, legal and social protections for children and women

**Promote** landmine-awareness programmes particularly those directed at children, and advocate for mine clearance operations

**Post-emergency phase**

**Reinstate** activities cited in the pre-emergency phase

**Reunite** separated children with family or surrogate households

**Support** the re-establishment of continuity and normalcy provided by basic schooling and recreational activities for children

**Support** negotiation efforts to demobilize and rehabilitate child soldiers

**Continue to monitor** the welfare of child prisoners
Chapter 7 – Annex 1: Evacuation of Children from Conflict Situations

In deciding whether and how to evacuate children from conflict areas, each involved party – children and their parents, first and foremost; national authorities; international and non–governmental organizations; and host countries – must consider the options, the risks and the potential benefits, and act on what is believed to be in the best interests of children and their families. No course of actions will be ideal, for the ideal situation of families being able to provide for their children in an environment of peace and tolerance has been temporarily destroyed. The attached UNHCR/UNICEF joint statements pertaining to the Former Yugoslavia, provide a number of key guiding principles and practical guidelines for use in situations where the evacuation of children is being considered. (UNHCR/UNICEF, 1992)

UNHCR/UNICEF Joint Statement on the Evacuation of Children from Former Yugoslavia

There continues to be well–meant efforts by Governments and non–governmental organizations to evacuate children from conflict areas, particularly Sarajevo. When any action affecting children is being contemplated, all parties must be guided by concern for the best interests of the children – the first principle of the Convention on the Rights of the Child, which states:

“In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities, or legislative bodies, the best interests of the child shall be a primary consideration.”

(Article 3, para. 1)

It is on this basis that UNHCR and UNICEF present the following key considerations, which must be taken into account when evacuation of children is being contemplated.

Numbers involved

There are more than 600,000 children under six years of age in Bosnia–Herzegovina, 281,000 of whom are in besieged cities, including 80,000 in Sarajevo. Given these numbers, it is clear that all children cannot be evacuated. Any evacuation which selects some children over others should not be done in such a way as to exacerbate ethnic tensions and conflict, and should be based on clear criteria.

Evacuation from Sarajevo by airlift

The primary mission of the airlift is to bring desperately needed food and relief into Sarajevo for the besieged population. Furthermore, sufficient security between the city and the airport and in the airport does not exist for the use of the airlift for evacuation. In light of this security situation and in an effort to maintain the fragile airlift operation, UNPROFOR and UNHCR have delineated a policy that only those persons whose medical situation is life–threatening and who cannot be treated with the facilities available in Sarajevo should be considered for evacuation by the airlift. Procedural guidelines for evacuation by airlift of such medical referral cases, including children, have been developed in consultation with WHO, UNICEF and ICRC and been distributed.

Evacuation in General

Several factors indicate that evacuation is not the most appropriate solution. In fact, evaluations of past evacuations have shown that evacuation often is more harmful than helpful to the children involved. These are some of the reasons:

• The trauma of being separated from the family is often greater than the trauma of remaining with the family in an area affected by hostilities and conflict.
• Initiatives for evacuation often come from evacuation organizers rather than from parents whose emotional stress in the duress of the situation may result in decisions which might not have been taken otherwise.

• Evacuations of children are often conceived as mainly logistical operations and may not necessarily be carried out by groups that have a proven record in child welfare, including assessing the best interest of the child, and in placement experience.

• There is great risk, particularly where large numbers are involved and there is a lack of resources, that the situation of the child will not be adequately documented and monitored. Children may become lost without the possibility of eventual return to their families. The length of separation is usually much longer than expected and may lead to estrangement of families and a loss of ethnic and cultural identity.

• Where displacement and ethnic relocation are goals of the hostilities, parties might be pressured to evacuate children for this purpose.

• Unexpected political complications may prejudice the outcome of evacuations. Whether the children are invited into a country, and when and if they return, may become political issues, particularly where proper groundwork has not been done.

Guiding Considerations

Family unity

No child should be moved without his/her primary caretaker. Respect for family unity is a guiding principle, clearly stated in the Convention on the Rights of the Child. Every effort must be made so that the family unit remains intact and the child is not separated from the family.

Unaccompanied children

Every effort should be made to trace the parents or other close relatives of unaccompanied minors [children] before evacuation is considered. Unaccompanied minors [children] are children who are separated from both parents and are not being cared for by an adult who has responsibility to do so.

Adoption

Adoption should be carried out in accordance with Article 21 of the Convention on the Rights of the Child. Adoption should not be considered if (a) there is hope of successful tracing or evidence that the parents are still alive, (b) it is against the expressed wishes of the child or the parent, or unless a reasonable time (at least two years) has passed to allow for tracing information to be gathered. Staying with relatives in extended family units is a better solution than uprooting the child completely.

Orphans

The issue of children occupying orphanages before the outbreak of hostilities and who can be clearly documented as orphans deserves special attention. Thorough assessment of the status of these children is very important and very difficult. Recent incidents have shown that alleged orphans turned out to have parents. Many unaccompanied children have living parents or close relatives with whom they may one day be reunited. If the status of an alleged orphan cannot be clearly documented, there is a risk of creating further problems of family reunification and tracing across country borders after hostilities have ended.

To be clarified before any evacuation of a child:

• Conditions of release and custody placement (identity of the child, documentation, family history, issuance and preservation of records);

• Conditions of admission and care in receiving country, including all financial and legal responsibilities;
• Measures to ensure/preserve relationships and communication with original family/original caretaker;
• Provisions for family reunion in the context of a durable solution.

Conclusion

Unless the above factors are carefully considered and implemented, UNHCR and UNICEF cannot endorse evacuations and/or request or advise governments or NGOs to evacuate children. UNHCR and UNICEF, with other humanitarian agencies on the ground, will continue to do everything possible to improve medical and social conditions locally, so that the safety and integrity of the child is preserved within his or her family and community.

Regarding the Evacuation of Children from Conflict Situations

In view of the persistent queries concerning the evacuation of children from war zones, here are some practical guidelines to be respected if evacuation of children is considered.

Protect and assist in place

Given the many serious problems associated with evacuations, UNHCR and UNICEF continue to urge that priority be given to providing adequate protection and assistance to enable families to meet the needs of their children. These efforts involve identifying the needs clearly and addressing them effectively so that people are able to choose to remain and keep their family units together. Greater support is required to strengthen and expand current programs.

Preserve family unity in evacuations

If it has been carefully determined that assistance and protection cannot be provided and evacuation is deemed necessary, the guiding principle must be the best interests of the child, e.g. that the evacuation would not lead to more harm than good for the child concerned. Experience has shown that the most effective way to reduce the likelihood of harm is to keep children with their parents or primary caregivers. Thus, any consideration of evacuation should be driven by action that enables evacuation of family units.

Evacuate only under proper conditions

It is recognized that there may be exceptional situations where there is a need to evacuate children without their parents or families. Such evacuations raise a number of fundamental issues related to child-care standards, including an assessment of the best interests of the child in terms of destination, reception and care arrangements, maintaining contact with the family, early reunification, etc.. UNHCR and UNICEF firmly believe that all the factors set out in the Joint Statement of 13 August 1992 and those elaborated below should guide all action during any evacuation. If these principles cannot be respected, the evacuation should be reconsidered.

Organizing/implementing evacuations

The following principles should be respected and the best interests of the child should prevail throughout:

• The choice of which children are to be evacuated should be reasonable, fair, and based on clearly assessed needs of the individuals concerned, as opposed to the needs of remaining children.
• The professional standards and capacity of evacuating agencies/individuals must be confirmed before entrusting the children to them.
• The decision of parents to send their children away must be based on full information and must be free and without coercion. Families of prospective evacuees should be provided information about the evacuating agency to whom they are entrusting their children, the intended child-care arrangements and the risks and possible consequences of evacuation.
Every effort must be made to abide by the parents’ wishes. The wishes of parents regarding the children’s care, culture and religious training must be followed.

- Children should be afforded the opportunity to have their opinion heard and considered.
- Parents or guardians (by law or custom) must give written consent prior to evacuation.
- For each child, personal and family particulars, with photos, must be recorded in a personal profile and history file. This file should also include full particulars of the agency to which the child is entrusted and copies of the written consent of the parents. One copy of this file should be given to parents. One copy should travel with the child. One copy should be retained by national authorities. One copy should remain with the agency to whom the child is entrusted, and one copy should be placed with a neutral monitoring agency (such as the Central Tracing Agency of the ICRC).
- Children should be moved to safe areas as close as possible to their homes and families. The location of evacuation should be determined by the best interests of the child, not only by the availability or subjective interests of donor organizations or families.
- Suitable evacuation, reception and care arrangements must be demonstrably available prior to the movement of children. Every possible measure should have been taken to assess travel conditions and ensure safety and appropriate care en route. If entry into another country is involved, the necessary approval, including visas, should be obtained before children are separated from their parents.
- Guardianship of the children (who will act in loco parentis) must be established prior to the movement of the children.
- Caring adults known to the children should accompany those evacuated without their families.

Reception and care

- The reception of the children should be well-planned, positive and humane so as to safeguard the well-being of each child.
- Evacuated children should be provided all the social services and legal protections available to children in the host country who are not in the care of their parents.
- The care and placement of children should be supervised by national or local child welfare services to ensure that they receive care that meets at least the minimum standards provided for national children.
- Siblings should be kept together.
- The most appropriate form of placement must be determined for each child. Age, personality, needs and preference of the child must be considered. For most children, family care will likely be most desirable. For some children, group care may be more appropriate. Clearly the most important criterion is that children are provided care that is age-appropriate, loving and nurturing, by continuous, rather than frequently changing, caregivers.
- Every effort must be made to preserve the culture, language and religion of the children, with full respect for the expressed preferences of the children’s families. Special efforts should be made to provide families of similar ethnic, language and religious backgrounds.
- Communications between the child and his or her family must be maintained, and special efforts should be taken to facilitate such communication.

Family reunification

Evacuations, reception and care should be planned with a view to the earliest possible reunification between parents and children. It must be clearly explained to guardians or foster parents that, although the duration of
the evacuation may be long, the objective is to return the child to his or her parents as soon as the situation permits.

Documentation for children should include sufficient travel documentation to enable easy return to countries of origin, as appropriate.


Chapter 8: Gender Issues

Rationale

Increasing evidence reveals that men and women are affected differently in the severity and nature of the impact of natural disasters, armed conflict and civil strife on individuals. While men, women and children are all affected by social and political upheaval, the effects vary and so must appropriate assistance strategies. Women and girls, by nature of their sexual and reproductive roles, and their social, economic and political positions in a given society, face severe physical and economic risks during humanitarian crises.

During conflict, in flight and in refugee camps, women and girls are extremely vulnerable to violence, sexual abuse and exploitation. As community structures crumble and levels of violence increase, they are no longer protected by traditional mechanisms. Women are also disproportionately affected by the harsh economic and social ramifications of crises. They are often forced to assume total responsibility for the survival of their families when their husbands, brothers, sons and fathers are killed, imprisoned, exiled or on combat duty. Given shrinking family resources, collapsed infrastructures and social and political unrest, this is often an impossible task.

The recognition of the differences in the natures and extent of the effects of crisis on women and girls is a crucial first step in addressing their gender-specific needs, which have traditionally gone unnoticed in the planning and delivery of humanitarian assistance.

Gender-Specific Impact of Crisis

General Aim

Given that approximately 80 per cent of refugees are women and children, humanitarian agencies have a responsibility to identify and address their needs and concerns.

UNICEF is concerned with the following gender-specific impacts of crisis. Each of these have critical consequences and implications for relief and development work.

Violence Against Women

Armed conflict increases women’s vulnerability to sexual violence and rape. Sexual violence is often used as a deliberate strategy of war. As traditional community structures and safety mechanisms break down, levels of individual stress increase, consistently putting women in fear of their personal safety and integrity. The threat and the reality of physical and sexual violence severely increase levels of psychological stress and trauma.

The destitution and fear for personal safety may lead to prostitution, exposure to HIV/AIDS and other STDs, abuse, and eventual abandonment and possible expulsion from their own communities.

The deliberate use of rape and other forms of violence or brutality against women and girls is being recognized as a war crime. New findings on gender crimes are fueling the continual debate on violence against women, and will hopefully enable the enactment of appropriate laws of protection and sanctions.
better understanding of women’s experience of gender crimes and persecution will contribute to a redefinition of refugee status for women both in their country of origin and during the exile period (see chapter 11, “Sexual Violence”).

**Women’s Rights as Human Rights**

Women’s rights are violated during war deliberately as a weapon of war or as a consequence of the breakdown of social structures. Discriminatory gender–related state policies can target both individuals and their families. Relationships within the household may reflect the way social institutions perpetuate men’s control over women’s time, leisure, sexuality, fertility, movement, inheritance and ownership. In times of war these relationships get exacerbated. The ability of state structures and social institutions to promote and enhance civil rights deteriorates during instability. Law and regulatory mechanisms become irrelevant or replaced by new arrangements for personal safety and security. This is particularly relevant to societies emerging from conflict situations where the physical and economic infrastructure, as well as the legislative and political institutions, are in the process of being restructured. Therefore, the adoption of a rights–based agenda by humanitarian agencies (see Annex 1) can lay the groundwork for an environment where the rights of women are respected and protected.

**Women and Health**

The maintenance of good health and of psychological health and nutritional well–being is critical to women’s ability to survive and carry out responsibilities. Women are also physically vulnerable because of their sexual and reproductive roles. Complications of pregnancy and birth remain untreated in the absence of medical services, and increased incidents of rape spread sexually transmitted diseases and lead to unwanted pregnancies. The reproductive health needs of women often go unaddressed, particularly in the planning of shelters and refugee camps. Due to discrimination in the allocation of resources and food, women are the first to suffer from anemia and from the effects of famine, which impacts their children and general well–being. In addition, injuries caused by landmines, cross–fire, violence, etc., cause disabilities, loss of limbs and eyesight, make them vulnerable to STDs, that further impair their ability to perform their roles and have life–long consequences.

**Livelihood and Production Strategies**

Crises increase the economic burdens of women, and armed conflict often destroys their ability to earn an income and grow food. Their land and other productive resources are either left behind or seized robbing them of the sources for their livelihood. Marketing and transportation systems may be destroyed. Often people are deliberately kept on the move in order to prevent resumption of economic activities. In the absence of men, the increased burden on women to find food, shelter and livelihood is further affected by ever–decreasing access to resources, be they credit, relief commodities, seeds, tools or access to productive land.

For the majority of women in the world, their major area of responsibility is the household and family. They are chiefly identified as a household member, as a mother, wife, sister, aunt, grandmother or niece. All these have varying degrees of status and obligation, depending on the cultural and community definition of ‘family’, ‘extended family’ and ‘household’. The impact of crisis on the household has severe implications for the individuals within it. Husbands, fathers and sons may be either killed, imprisoned, forced to migrate, conscripted into armies, abducted or disabled. The women members may be forced to take part in armed conflict by providing sexual and other services to combatants. During flight and forced separation, families are broken up and the load on women becomes even greater with the loss of economic and social/emotional support.
Discrimination Against the Girl Child

Within emergency situations, discrimination and vulnerability are often doubled for the girl child. Due to her age and relative innocence, she is at high risk for neglect, sexual violence and trauma, abduction and enforced labour. Young boys are also at risk.

Special monitoring mechanisms and strategies are needed to ensure the rights of girls and their basic needs are met in refugee camps, shelters, orphanages or other settlements.

Crises can also traumatically impact women’s personal identity and sense of self−worth in complex ways. Changes in gender roles, family status and livelihood caused by conflicts and crises can all affect women’s identity, particularly since their status is often culturally defined. The loss of husband and children may lead to a severe loss of identity if women’s status is defined purely as mothers and wives. Furthermore, rape as a personal and social attack in a crisis results in both loss of self−worth, and may lead to stigma and marginalization from the community.

Even loss of cultural adornments, clothes, head coverings and other forms of traditional dress during crises can in some societies affect women’s identity and restrict their mobility, for example, their ability to take part in relief programmes and attend food distributions.

Many women may find that forced changes in roles (such as serving as combatants or being the sole supporters of their households) can temporarily strengthen their position. However, after the crisis and a return to previous conditions, they may find themselves under even more restrictions since the social structures have not taken into account the change in women’s roles.

The introduction of new nationalist or religious fundamentalist ideologies can redefine women’s role and status, and impact their position, rights and access to services and citizenship in a society. Understanding the extent to which women are empowered or disempowered in ethnic national movements and civil wars is critical to the effective implementation of support strategies in reconstruction.

Field−Level Strategies and Actions

Although gender issues are not confined to or isolated within the emergency context, several specific programmatic concerns and strategies should be integrated into UNICEF’s emergency response.

Access to basic resources

In order to increase the survival of children and families, UNICEF’s basic services need to target women and girls directly, particularly to overcome discrimination in the allocation of resources and food. Women’s reproductive health issues must also receive greater attention.

Gender−specific monitoring and evaluation

Gender−specific indicators should be included in needs assessments, situation analyses and programme evaluations. This information can then be used to develop specific methods to target and distribute resources to women, including, for example, the identification of distribution points in areas where women are free from harassment and other forms of gender violence.

Gender violence

The protection of women and girls must receive local, national and international attention. National legislation and covenants supporting the protection of women and girls should be a part of UNICEF’s advocacy work. International laws must be upheld and strong consequences for gender violence enforced.

Training of Peacekeepers

The UN and UN agencies need to orient and train peacekeeping troops and and civilian police on gender issues. All efforts must be made to enforce laws that prevent the violation of women and children’s rights.
Increase in women’s participation and rights awareness

Women’s participation is critical to all aspects of planning, assessment, monitoring, and service delivery. Increased involvement ensures that women receive basic resources and services and increases sensitivity towards cultural norms.

UNICEF has a responsibility to involve women in the decision-making process as well as to support their representation in local governance and national government positions. On the local, national and international levels, women need to be involved in matters related to humanitarian assistance and peace building. Women are not passive victims of political violence but play a crucial role in resisting political oppression, forging conflict resolution, promoting peace-building, and rebuilding their societies. In areas of mediation and negotiation, political settlement, human rights, and justice, the participation of women is crucial.

Suggested activities:

• supporting women’s groups and peace-building efforts;
• supporting human rights education and leadership training of women and girls;
• developing systematic reporting of women’s rights violations;
• promoting the organization of women’s groups for security patrols;
• advocating for attention to gender equality in peace agreements and national legislation;
• increasing awareness of the Convention on the Rights of the Child, and the Convention on the Elimination of All Forms of Discrimination against Women;
• ensuring gender balance in staffing and recruitment of personnel;
• including gender sensitivity in the training of Emergency Response Teams;
• linking with national and international research institutions, centres of excellence, and networks to enhance UNICEF’s capacity for gender-sensitive planning, training and advocacy. The first step is reference to existing programme guidance in the UNICEF programmer’s guide on gender mainstreaming.

Relief and development

UNICEF should support sustainable development through women’s income-generating projects. Displaced women have no viable income and those returning home often find their agricultural plots filled with landmines, marketing and transportation systems destroyed, and access to resources severely decreased. Advocacy for new legislation that protects the rights of women to property is essential.

Traditionally, women have had little access to development projects such as reforestation or infrastructure development, or to agriculture skills or little opportunities to attend training and skills development programmes. Occupational training has usually been geared towards males and women are exposed to at best functional literacy. Post-reconstruction relief efforts must be more available, accessible and relevant to women and their needs of employment. Concrete projects to increase women’s economic capacity and social participation must be developed.

Further Guidance

Bushna, E., S. Piza, and E. Lopez, Development in Conflict: The Gender Dimension, Oxfam Publications
Parente, P., Women and Emergency Settlements, 1989
Chapter 8 − Annex 1: Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) 18 December 1979 (extracts)

CEDAW obliges States to take concrete steps to eliminate discrimination against women and to implement various measures towards its elimination.

CEDAW obliges States:

• to condemn all forms of discrimination against women and to implement various measures towards its elimination;

• to eliminate discrimination in education;

• to ensure the same conditions for career and vocational guidelines and for access to studies;

• to ensure the right to work and the right to the same employment opportunities with equal remuneration;

• to provide special protection to women during pregnancy in types of work proved to be harmful to them;

• to eliminate discrimination in the field of health care and to ensure access to health care services and appropriate services in connection with pregnancy;

• to eliminate discrimination against rural women in particular;

• to ensure equality before the law;

• to ensure the same rights and responsibilities with regard to marriage and guardianship, wardship, trusteeship and adoption of children. In all cases the best interests of the children shall be paramount;

• to eliminate discrimination in the political and public life of the country;

• to ensure the same rights in respect of the ownership, acquisition, management, administration, enjoyment and disposition of property.

Additional References


Chapter 9: Early Childhood Development and Protection
**Rationale**

UNICEF’s primary service role in emergencies is the protection of children. The most vulnerable time for children to be impacted by emergency conditions and violence is early childhood. The vital role of the early years in the formation of intelligence, personality and social behavior is well established. During the formative years of birth to age 6, the child encounters some of life’s most significant learning experiences and develops competencies that are the underpinning of all later learning. It has long been accepted that good health and nutrition support the psychological and social development of the young child. Less widely recognized are the findings that developmentally sensitive interaction with a child—namely interaction that satisfies the child’s need to grow socially, emotionally, and cognitively—has a measurable impact on the health, nutrition and learning capacity of the child.

**Child Development**

Child development describes a process of change as children grow and mature. The study of child development helps us to understand how children learn to handle more complex levels of moving, thinking, feeling, and interacting with people and things. For children to develop to their full potential, basic needs of protection, nutrition and health care, must be met, along with needs for affection, interaction and learning through exploration and discovery.

Research has clearly demonstrated that there are critical points in children’s development where it is essential to ensure the kinds of experiences and interactions that support healthy growth and development. For children to reach their potential and avoid later dysfunctions, they must not be subjected to an accumulation of risk factors.

**General Aim**

UNICEF’s overall aim for young children living in emergency or violent situations is to prevent the accumulation of risk and enhance the social and psychological resources that underlie coping and resilience. The challenge is not simply to reduce risk factors that threaten development, but to overcome them by building on protective factors that exist naturally in children’s families and communities and to provide support when they are absent.

The greatest risks to development are early deprivation that suppresses intelligence, repressive environments that stultify creativity and foster rigid thinking, and environments devoid of basic resources that affect healthy physical and mental development. All three threats are common for children living in emergency conditions.

**Impact on Young Children**

**What happens when risk replaces safety as a condition of life for a child? How does chronic danger affect the young child’s growth?**

At the most basic level, living in chronic danger suppresses the development process itself. It immobilizes children, inhibits exploration and thereby impairs the development of competence. In the early years, children form a picture of the world and their place in it. If a children’s picture is of a hostile world and they see themselves as insignificant players, suspicion, limited capacity to learn, low self-esteem, self-denigration, and perhaps violence and rage can be expected. For some children, emergency and/or violent conditions can stretch their coping mechanisms to the breaking point.

**What about the role of communities and parents in compensating for these risks?**

Violence threatens children not just directly but indirectly through its effects on adult caregivers. The adults are often themselves traumatized. Their experiences with violence and deprivation reduce their capacity to meet the needs of the children they care for. The harsh realities of their lives reduce their capacity to provide the nonviolent nurturing their children so desperately need.

**Brain Development**

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The influence of the early environment on brain development is long-lasting. Early exposure to good nutrition, objects to explore and stimulating interaction with others has a positive impact on children’s brain functions later in life. These effects appear to be cumulative. Furthermore, children who experience extreme stress in their earliest years are at greater risk for developing a variety of cognitive, behavioural and emotional difficulties.

Young children living in situations of armed conflict are in double jeopardy:

- They are in danger of becoming the victims of violence.
- They can become accustomed to violence, losing the ability to empathize with victims.
- They can take on the role of the aggressor. It is the destructive accumulation of risks factors that jeopardizes development, particularly when there are no compensatory forces at work.

The rapidly accumulating scientific evidence on the importance of the early years of the child’s life has been reinforced by a wealth of programme experience. The long-term benefits associated with increased investment in well-conceived and properly managed programmes is well documented. These benefits include:

- a healthier child population that is better educated, trained, more able to obtain employment and keep productive;
- less repetition and dropout in school;
- lower delinquency rates and ultimately lower expenditure on welfare and social services;
- increased ability to cope with stress and conflict later in life.

Policy analysts, programmers and child development specialists have recognized the dire need to direct this knowledge towards interventions that respond to the needs of young children and families living in emergency situations and violence.

Building on UNICEF’s current ECD strategies, this chapter addresses some of these questions and suggests several interventions that can support the capacity of families and communities to care for their youngest members in emergency situations.

Basic Principles

Benefits of ECD Programmes

The long-term benefits that result from investing in early child development (ECD) programmes received renewed attention during World conference on Education for All, Jomtien, 1990. The need to expand programmes that address the intersecting need of parents, infants and young children and the most basic of all social units, the family, was fully acknowledged.

The UN Convention on the Rights of the Child (CRC) provides the legal framework and set of standards to guide all work to assist children in situations of armed conflict, including children in their earliest years. Articles of the Convention with particular relevance to early child development include:

Article 5. “State Parties shall respect the responsibilities, rights, and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom....to provide, in a manner consistent with the evolving capacity of the child, appropriate directions and guidance.”

Article 18 (1). “State Parties shall...ensure recognition of the principle that both parents have common responsibility for the upbringing and development of the child.... The best interest of the child will be their basic concern.” (2) “State parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.”

Article 27 (1). “State Parties recognize the right of every child to a standard of living adequate for the child’s physical, mental, spiritual, moral and social development. (2) The parent(s) or others responsible for the child have primary responsibility to secure, within their abilities and financial capacities, the conditions of living
necessary for the child’s development. (3) State Parties...shall take appropriate measures to assist parents and others responsible for the child to implement this right...."

In keeping with the humanistic value of the child reflected in the CRC, the following principles guide the development of early childhood programme strategies.

**Cumulative risk and early development:** A child’s development reflects the mutual effects of the environment on the child and the child on the environment. Children are at-risk of developmental harm as a result of an accumulation of high-risk factors. No single risk factor predicts developmental arrest. It can not be assumed that an environment characterized by chronic violence categorically predicts a given outcome.

**Resiliency:** The impact of stressful or traumatic events depends on the balance between stressful experience and protective factors for each child and on the compensating factors in the environment and the culture. When they exist, these factors serve to immunize, buffer or neutralize the impact of the assault. Interventions must be based on the premise that children are developmentally normal, are resilient and have the potential for success when they are provided with a carefully designed and developmentally appropriate learning environment.

**Early intervention:** Action needs to be taken as early as possible to prevent the long-term suffering that can be anticipated for many children. The goal of early intervention is to prevent the build up of risk factors in the lives of children and families. Prevention is the foremost goal; however, where prevention fails, specialized intervention services must be provided to help develop coping skills and to keep the challenge facing these children within the limits of their ability to cope.

**Family support:** Families, and the factors that contribute to resilience, must be understood, supported and strengthened. Programmes must be able to address the needs of a range of non-traditional family units and to strengthen the many and varied relationships that provide sustenance, comfort and protection to children in emergency situations. Critical relationships vary depending on the ages and circumstances of the child.

**Caregiver training:** Training, supervision and ongoing support needs to be provided to those working with children in these highly stressful situations. Recognizing and addressing the stress and risks associated with working with children, families and communities affected by organized violence must assume a central position in the training of caregivers.

**Holistic services:** Children’s needs are holistic, covering all domains of their development. Therefore, adherence to holistic principles is critical for effective programming. Attention to physical and survival issues must be complemented by equal attention to psychosocial, emotional and developmental needs. Recognizing that these needs cut across sectoral lines, mechanisms must be created that enable programme linkages, collaboration, and complementary service delivery.

**Community participation and mobilization:** The recovery and renewal of communities devastated by war, violence or other emergencies requires a framework that encourages the community to take an active part in articulating problems and designing and implementing solutions. Through participation, communities often become mobilized on behalf of children. Programmes must value indigenous knowledge, skills and coping patterns of the community, and be based on traditional cultural wisdom to limit aggression and alleviate children’s stress.

**Programmes as protection:** By providing a secondary care-giving and learning environment that complements and supports the family, ECD programmes can play a vital protective role. These positive experiences foster the development of coping skills and self-esteem and reduce the potential for developmental delay or arrest. Peer groups provide invaluable opportunities for play and development of critical social and problem-solving skills, which can be essential in survival situations.

Special relationships with children and caregivers give children a sense of belonging at a time when family units and caregiving may be disrupted. Programmes must be designed within an overarching structure or ethos of nurturing, combined with developmentally appropriate and educationally enriching experiences. They must support and extend the role of parents and families in caring for young children.
Identifying Needs

Generally the loud or initial stage of an emergency is characterized by chaos and little organized activity. It is critical at this point to determine the status of young children and to analyse the situation to prioritize needs and determine how these will be met. Later, during the transition stage, it is possible to work toward normalcy. The ultimate return of structure, purpose, responsibility, self−respect, and achievement can help mobilize a community and provide the basis for additional developmental activities.

Early childhood development (ECD) activities can be initiated as soon as possible, even if they are simple. They can be built on over time. The creation of ECD programmes can help bring a degree of normalcy to people’s lives, especially to the lives of children. Ultimately the goal is to design interventions that reach the widest possible audience and can be sustained over time. This requires a continuum of services that moves from an immediate protective response to a set of transition activities followed by those that facilitate reconstruction and rehabilitation.

Field−Level Strategies and Actions

Developing Appropriate Interventions

Four basic parameters must be considered:

- stage of the emergency
- the status of those affected by the emergency (refugees, unaccompanied children)
- the specific characteristics of the population (age, educational level, skills, competencies, and experience with violence)
- available resources, both human and material
- The relationships between these parameters determines the programme design

Programme experience in early childhood has grown in recent years, providing a wide range of examples and insights to be drawn upon. In an attempt to counter the narrow ‘institutional’ often expensive, and age−restricted image associated with pre−school programmes, seven complementary programme strategies for early childhood have been developed.

Each programme has a different objective and is directed towards a different audience. Empowering parents and families has evolved as the cornerstone of UNICEF’s strategies. Community−based programmes that complement the capacity of the family to care for their young children have also received UNICEF’s attention and programme support. This section outlines the application of these two strategies for delivering services to young children and families in emergencies.

Empowering Families and Caregivers

Addressing the needs of the child

The primary responsibility for children’s development lies with their parents and immediate family members. Parents are a child’s first teachers, first caregivers and most important life−long educators. Therefore, any activities that aim to enhance early childhood care and development must start by supporting parents and building upon the efforts they make with their children. The assumption is that an informed parent can respond more skillfully than an uninformed parent to the range of child−rearing activities and responsibilities. The specific content varies widely. The special needs of parents caring for children in emergency situations must be integrated into current programme approaches.

Parents are generally concerned about their child’s reactions to difficult situations. However, parents may underestimate both what the child has experienced and how severe the child’s reactions are likely to be. They are often reluctant to talk to their children about traumatic events. Children sensing their parents’ emotional vulnerability choose not to share their feelings, imaginations and thoughts.
**Early Childhood Strategies**

- Empowering families and caregivers
- Supporting community-based programmes for children
- Promoting community partnerships
- Strengthening national resources and capabilities
- Strengthening demand and awareness
- Developing national child and family policies
- Developing supportive legal and regulatory frameworks

Some parents may have difficulty recognizing and attending to the child's distress because it serves as a reminder of what the adult wishes to forget. One manifestation of the psychic numbing and avoidance in traumatized adults may be an insensitivity to symptoms in a young child. Some parents may become overprotective hardly allowing their children out of their sight. Many who were abused emotionally, physically or sexually as children are burdened even further by the lingering effects of such past violence.

A lack of communication and understanding between children and parents is harmful during emergencies, as it does not allow relief from the mental and emotional stress. Children need to have their questions answered and have a clear picture of the events, its antecedents and its consequences so they do not have to rely on assumptions and fantasies, which may be worse than reality. It is not necessary, however, for young children to be burdened with every detail of a situation.

Young children do experience violence and do try to understand it, and they do remember it. We must pay attention to their experiences. We must learn to comprehend the meaning of violence for young children, especially when they do not have language to help them organize their experience and express their feelings. There is no way to immunize infants and young children against the plague of violence, devastating much of the world. But there are ways to protect children, to heal them, to nourish the resilience of childhood, and to keep hope alive.

**How do we help children who experience horror not as a single event that disrupts the normal flow of life but as something that is constant?**

Children living in armed conflict must find a way to make sense of a world in which horrible experiences become a part of the fabric of life.

The children who manage to thrive in spite of the harshness of the environment that surrounds them have much to teach. They remind us that competence, confidence and caring can flourish even under adversity if children develop secure bonds with caring adults, if their basic needs are met and if they have opportunities to develop essential knowledge, skills and values. They also teach that while missed opportunities early in life are more difficult to recapture, it is never too late to try.

The behaviour patterns common among young children exposed to violence (see Panel 1), as well as the specific symptoms exhibited by severely traumatized children, are discussed more deeply in Annex 1. Annex 2 suggests ways to help parents talk to their children about trauma.

**Addressing the needs of parents/caregivers**

Protecting children is a family’s most basic function. Regardless of their composition, families are uniquely structured to provide the attention, nurturing and safety that children need not only to survive but also to grow and develop. An important psychological aspect of parenting an infant or toddler is being able to provide what has been called a ‘holding environment’, or space in which parents can protect a child from danger and allow some measure of independence.

**Symptoms of Traumatized Children**

- re-experiencing the event
- numbing of responsiveness
• increased arousal
• loss of self-esteem
• loss of security
• identification with the aggressor.

Parents who cannot protect their children from violence or harsh conditions are likely to feel frustrated and helpless. They may feel powerless in relation to circumstances beyond their control. Parents who live in poverty and stressful environments are more likely to experience symptoms of depression, such as disturbances in sleep and appetite and chronic exhaustion.

In addition to understanding children’s reactions (see Panel 2), parents must be supported to cope with their own traumatic experiences. Parents have to know that reactions they experience after traumatic events are normal, that talking about their experiences provides relief and helps them to return to their previous level of functioning.

Trauma-affected families often suffer from children’s behavioural problems, family conflicts, marital problems and violence, and abuse. Parents have to learn to accept each others stress-related behaviour as normal. They must acquire skills that enable them to talk to each other without anger. They need to find ways that they can help each other to change the family situation.

Specific actions

A variety of strategies can be identified to provide parents with child development knowledge and skills as well as to address their own responses to trauma and chronic stress. When done well, they build on the strength of families, putting greater emphasis on the role of parents in supporting their own children’s early learning and development. The relevant knowledge, skills and behaviours can be delivered through home visits, parent discussion/support groups or through mass media.

Parent Education

Parent education programmes should provide parents with specific skills and activities that they can use in their interactions with the child and help them to:

• understand the normal reactions of children to stress and trauma, and the meaning of symptoms or behaviors at different ages;
• utilize effective behavioral management strategies;
• refocus attention to basic care-giving skills;
• develop skills to help them talk to their children about traumatic events.
• provide normal play and nurturing interactions.

Workshops/support groups: These include opportunities for parents to come together to discuss child development and their role in the process. Such groups offer opportunities for families to exchange experiences and receive support in daily tasks. The group focuses on both practical training and information about children’s needs at different stages of their early childhood development as well as advice on how to respond to their changing needs. Play and learning activities for young children can also be offered. These provide parents with opportunities to observe their children and discuss their behaviour problems with each other under the guidance of a helpful adult. The playgroup can also be used to demonstrate the implementation of educational strategies that can help children overcome their behaviour problems and develop new capabilities.

Home visits: This is another useful parent education model. In this approach, experienced parents provide information and support to less–experienced parents in their own homes. The importance of this peer–to–peer support and interaction cannot be over–emphasized, in that it mimics traditional methods of passing on knowledge, a method that often disappears in emergency situations. When such interactions are part of well–planned programmes that includes training, support, supervision, and relevant materials, they can achieve impressive outcomes.

Use of media: Parent education efforts can also be built around the media–radio, television and print–to
provide parents and caregivers access to child development knowledge and skills.

Supporting Community-Based Child Development Programmes

Sharing traumatic experiences helps parents to:

- reestablish a sense of togetherness and support
- get relief from extremely intensive impressions and feelings;
- restructure thoughts and actions
- re-evaluate realistically what happened
- create plans of how to return to a normal life
- develop hope for the future

Specific actions

The immediate goal of this direct approach is to enhance child development by attending to the needs of children in quality programmes/activities organized outside the home. These alternative environments to the home recognize the need for parents and children to have time to do things separately and for young children to socialize together in groups (see Panels 3 and 4).

Bringing children together: It is important to find a place where children can gather together, and to make it a permanent site that is reserved for the children. This fosters security and brings some predictability into the child’s life. Generally there is no problem of attendance at such programmes. Children crave the company of other children. Groups activities provide children with social skills as well as new knowledge. When interacting with peers, children can share their experiences through playing, talking and learning from each other.

Involving communities: Communities should be involved in developing the programme, designing and operating the activities, and managing resources. Community involvement at all stages increases their ownership and thus the likelihood that the programme will be sustained. Utilizing what exists within the community, such programmes become a rallying point for a whole variety of community-based efforts.

A variety of models exist for providing informal community-based child-development activities, including:

- home-based day care;
- community-based integrated child-development centers;
- neighbourhood playgroups;
- child development activities linked to other services, e.g. women’s income-generating groups, medical services.

Mobile units containing resources and activities that promote child development and early learning have also been used to serve the needs of children in hard-to-reach communities. An alternative strategy is to integrate early child development activities into other existing programmes that address the needs of young children and families. The following suggestions have been successful.

- Add child development components to health or community development projects to promote awareness of the needs of young children.
- Address children’s needs in conjunction with women’s programmes. This can be done through creating a child-care programme that also meets women’s needs to engage in income-producing activities.
- Link early childhood programmes with primary schools. Address the needs of both young and older children through child-to-child projects which bring children together in educational exchanges that benefit both. The 'school in a box' strategy developed for primary school children living in situation of armed conflict could be applied to meet the needs of young children.
How Young Children Learn

- Children construct knowledge.
- Children learn through social interaction with adults and other children.
- Children learn through play.
- Children’s learning reflects a recurring cycle that begins in awareness and moves to exploration, to inquiry and finally to application of new knowledge.
- Children’s natural interest and ‘need to know’ motivate learning.
- Children’s development and learning are characterized by individual variation.

With training and ongoing support, caregivers can help counteract the negative conclusions a traumatized child may draw about self-worth, about the reliability of adults and their institutions, and about staying safe in the world.

The training component is perhaps the most important factor in implementing ECD programmes. Training strategies must enable learners to acquire flexible skills and knowledge transferable to their particular tasks and roles. Training is not a package to be dispersed but a process of developing knowledge, awareness, understanding, and the acquisition of skills and competencies. It begins with what people know about people, children and themselves, and integrates the necessary new skills and knowledge. A successful training strategy for ECD is one that:

- emphasizes the learner’s strengths rather than weaknesses
- applies active and participatory training methods
- perceives the trainer as a facilitator rather than a director
- provides a model for the teaching/learning process of a good ECD programme

“I want to know more about how to structure an environment in which frightened children can be calm, the timid dare to emerge from hiding and those too worried to speak and play can learn to tell their own stories and listen to mine. For, by now, we must all realize that when we acknowledge and learn to deal with children’s emotional need in the classroom, we directly influence their social and cognitive development.”

--- Vivian Gussie Paley

Caregivers must be emotionally accessible and cognitively competent to understand the child’s experiences. Therefore, in situations of violence and armed conflict, training efforts must recognize and address caregivers emotional response to trauma, loss and grief. In addition ECD training programmes should include (see Panel 4):

- knowledge and skills in child development
- developmental consequences of risk and trauma
- protective factors and resilience
- interpersonal skills

Interventions that Heal

Models for Programming

A variety of models exist for providing informal community based child development activities including:

- home based day care,
- community based integrated child development centers,
- neighborhood playgroups.
The ECD interventions proposed here are primarily supportive, educational and preventive. They recognize that the majority of ‘at-risk’ children are developmentally normal not pathologically disturbed and have the potential for success when their environments are sensitive to them and their burdens. They emphasize the role of the caring relationship with significant adults as the principal agent of change and source of support. Through training, consultation and supervision, we can help adults provide a developmentally appropriate and facilitative environment that is also responsive to the unique social, emotional and physical problems children face.

**Care giving, learning and support: Relationships as foundation**

Although ultimately the motivation to learn comes from within, early learning is initially a process of identification with emotionally important people in a supportive climate. Adults do not affect children by the transmission of specific skills alone but through their values, climate, quality of relationships. Especially in the early years, the content is almost incidental. Children learn by internalizing the attitudes, values and ways that are meaningful to them. Through this foundation, children will learn whatever content they are exposed to.

**Structure and control: Environments that hold**

What emerges from a review of resilient children is the importance of structure and control—the need for order and predictability in a safe and disciplined, but not rigid environment. At-risk children seem to need and benefit from structure at many levels to enhance resilience and security in the family and in child-care environments. The need for structure and control appears to be more critical in conditions of severe deprivation, chaos and uncertainty. Well-ordered, predictable, physically and psychologically safe environments support the development of competence and confidence. The child experiences this environment as: “I know where to go here; I know what to do here; I know what happens next; I know who will take care of me when I need help.” Children struggling with traumatic events are helped by an environment that can take over when their own coping abilities are diminished by stress. In such an environment, children rise to the potential of their own inherent strengths.

- Programmes that develop resilience in children exposed to high stress include:
  - an opportunity to develop strong relationships with adult role models and other children in nurturing settings of warmth and caring;
  - a predictable, safe environment with clearly defined structure and consistently enforced standards, rules and responsibilities;
  - developmentally appropriate opportunities for enhancing self-esteem and developing learning and coping skills.

**Coping and self-esteem: A developmental approach**

Programmes based on a child-centered developmental approach support a child’s self-righting tendencies, inherent strengths and potential for resilience – coping abilities that translate into self-esteem and even survival. Such an approach acts in two ways. It supports the child’s current developmental needs, thereby fostering growth, while at the same time it provides opportunities to rework earlier stages of development.

In addition, programmes designed with sufficient flexibility and sensitivity to adapt to individual needs ensure that a child can shift between higher and lower states of functioning. These opportunities help the child develop coping skills to deal with past or present trauma without losing self-esteem. Young children develop resilience not when stress and adversity are completely removed from their lives but, rather, when they encounter graduated challenges that enhance their competence and confidence. Care-givers provide nurturing and support, manage stimulation, anticipate needs, and provide relaxation and comfort. In managing the quality and quantity of stimulation, setting protective and realistic limits, and in providing comfort, support, approval, and acceptance, care-givers nurture the building blocks of self-esteem.

**The Limits of Resilience**

An attempt has been made here to acknowledge the terrible threat to children posed by violence and other trauma while at the same time affirming the capacity of children to recover by asserting that children are not doomed.
Children are resilient, but their resilience is not without limits. They are not invulnerable. Children with basic resources – physical and social – are more resilient. Children living in war zones or extreme conditions are burdened with risk factors and stripped of protective factors. They are poor. They often come from families lacking positive role models – families often headed by single women whose own personal struggle saps their strength. They are often minorities who have suffered a history of discrimination. They are often plagued by health problems attributed to prenatal conditions, inadequate health care, and poor nutrition. For these children, violence or armed conflict is often the final blow.

Risk accumulates – slowly and quietly robbing the spirit of childhood and the capacity for children to become what was theirs to create. Developmental damage is left in its wake. We must search for every opportunity to enhance resilience, promote coping, and prevent risk. Emergency assistance efforts must include components that help communities structure and sustain environments in which frightened children can be calm, the timid can dare to emerge from hiding, and those too worried to speak can learn to tell their own stories and listen to ours.

Children living in conflict areas cannot tolerate inferior or insensitive programmes. Can we bear to offer anything less?

Further Guidance

Child−to−Child and Children Living in Camps’. TALC, P.O. Box 49, St. Albans Herts AL1 5 TX, United Kingdom


Evans, Judith. ’Children as Zones of Peace: Working with Young Children Affected by Armed Violence’, Coordinators’ Notebook, No. 19, 1996


--- E.E.Werner (1990)


Panels

Panel 1 – Children’s Reactions to Traumatic Experiences

<table>
<thead>
<tr>
<th>CHILDREN’S REACTIONS TO TRAUMATIC EXPERIENCES</th>
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<tbody>
<tr>
<td>Infants</td>
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<tr>
<td>• withdrawal</td>
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<td>• clinging</td>
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<td>• restlessness</td>
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Panel 2 – Normal Adult Reactions to Traumatic Experiences

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<tr>
<th>NORMAL ADULT REACTIONS TO TRAUMATIC EXPERIENCES</th>
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<tbody>
<tr>
<td>Immediate Reactions</td>
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<tr>
<td>• shock</td>
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<td>• sense of unreality</td>
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<td>• freezing or storm of emotions</td>
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<tr>
<td>• extreme attention and alertness</td>
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<tr>
<td>• misperceptions</td>
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<td>• continuation of routines</td>
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Panel 3 – ECD Programmes: Supporting Children, Parents, Communities

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<tr>
<th>ECD PROGRAMMES: SUPPORTING CHILDREN, PARENTS, COMMUNITIES</th>
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<tr>
<td><strong>For children:</strong></td>
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<tr>
<td>• re-establish safety, security and protection</td>
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<td>• secure their physical well-being through proper nutrition and health care</td>
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<td>• encourage them to continue normal activities</td>
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<td>• help them to understand their experiences by giving more information</td>
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<td>• help them to process their sensory impressions and emotions</td>
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<td><strong>For parents:</strong></td>
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<tr>
<td>• give them information about normal behaviour problems of traumatized children</td>
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<tr>
<td>• teach them methods of behaviour management</td>
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<tr>
<td>• help them to overcome their own traumatic experiences</td>
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<tr>
<td>• support and guide them to provide their children with appropriate care and education</td>
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<td>• give practical assistance in restoring basic household functions</td>
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<td><strong>For communities:</strong></td>
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<td>• maintain or restore basic public services</td>
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<td>• include all members of the community in reconstruction activities</td>
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<td>• offer community meetings and facilitate mutual support</td>
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<td>• encourage cultural traditions that strengthen people’s sense of identity and belonging and promote communication between communities</td>
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<td>• facilitate political understanding and provide religious guidance</td>
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Panel 4 – Promoting Quality Programmes

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<th>PROMOTING QUALITY PROGRAMMES</th>
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<td>There is a wealth of existing material, for people working with children, on various aspects of ECD programme design, implementation and evaluation. These are available in many languages and at different levels of literacy. Training methodologies have been developed to help caregivers, parents, teachers, and trainers to understand and communicate the issues more effectively. In drawing on this body of knowledge, the following questions should be considered:</td>
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<tr>
<td>• To what extent can existing ECD materials and methods be applied to children in emergency situations?</td>
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<td>• How and in what ways do they need to be adapted?</td>
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<tr>
<td>• What additional approaches/linkages might need to be further developed particularly in respond to the initial phase of the emergency?</td>
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Regardless of where they are conducted and how they are organized, early childhood programmes that offer daily activities are essential to the normal development of every child. These activities must be based on an understanding of learning and teaching as an interactive process and a set of basic assumptions about how young children learn.

Panel 5 – Content of ECD Training Programme

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<th>CONTENT OF ECD TRAINING PROGRAMME</th>
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<td>The training content must be organized around a child–centred approach that recognizes children at various levels of development. Caregivers should have a working knowledge of basic child development in the context of family, culture and community. They must be able to organize activities for independent problem solving, and provide opportunities for meaningful child–initiated conversations with peers and adults and ample time for exploration of the environment.</td>
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The role of play and art should receive special emphasis for its significance as a developmentally appropriate therapeutic intervention of particular value for children at risk. Using locally available materials to foster children’s creativity is a critical component of the training (see Annex 4).

**Developmental consequences of risk and trauma**
Caregivers should comprehend the nature and the meaning of ‘risk’, the potential for developmental harm resulting from exposure to temporary or prolonged stress and trauma, and recognize behaviour suggestive of an underlying problem. It is crucial for child–care providers to understand the relationship between exposure to chronic, cumulative risk and the resulting psychological, physical and behavioural effects that may impinge on the overall development of at–risk children.

**Protective factors and resilience**
Within a framework of developmental appropriateness, training should address the interpersonal and traditional practices that contribute to the development of resilience in children. Child–care providers must be able to assess the factors that interfere with or facilitate the capacity of these children to develop and learn (see Annex 5).

**Interpersonal skills**
Caregivers must also develop skills in interpersonal relationships between adult and child. Emphasis must be placed on helping children to recognize feelings, clarify issues, correct distortions, solve problems, and decide on alternative solutions. Such skills enable teachers to create an environment that promotes growth, self–esteem and self–control.

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Chapter 9 – Annex 1: Violence and Young Children: Behavioural Consequences

This review highlights some of the behaviours manifested by young children suffering from violence as well as the symptoms associated with traumatic experiences. The spiritual and philosophical symptoms of trauma in children are also reviewed.

**Behavioural Manifestations**

Years of research have taught us that children develop the sense of basic trust and security that allow them to feel free to explore and master the world through their daily experiences with parents and other important caregivers. When parents are anxious, fearful, depressed, or numbed by the stress of living in a violent environment and behave unpredictably, young children tend to show patterns of disorganization in their own behaviour. Infants and toddlers who are at an age usually characterized by eager exploration of the world, refueled by comfort and reassurance from adults, tend in violent environments to show fear, confusion, and inappropriate emotional response to distress. The distortion that occurs in the relationships of young children exposed to violence may represent the most damaging and far–reaching effects of their experience.
A young child may reduce overall activity and engagement with the world in response to the sensory overload produced by a terrifying experience or series of experiences. Just as an adult’s coping mechanisms may be useful in dealing with the crisis of violence and may interfere with good parenting, a young child’s mechanisms for coping with exposure to violence may interfere with the child’s primary developmental task—learning. In order to interrupt such a cycle, which may contribute to the child’s development of a negative self-concept, parents, caregivers, and clinicians should be alert to signs of:

- Selective inattention—a restriction on the amount of information that the child attends to in the external world;
- Increasing cognitive rigidity—limitation on how much complex information about the environment the child processes;
- Reduced mastery motivation—lack of curiosity and pleasure in exploring the physical world of objects.

In studying the effects of abuse and neglect on infants, four clinical patterns have been described:

- a developmentally and affectively retarded group, who were socially and affectively muted and dull;
- a depressed group, who were sad and sensitive to rejection;
- an ambivalent group, who had rapid shifts of emotions;
- an angry group, characterized by emotional intensity and low frustration tolerance in addition to extremes of anger.

It is important to understand these patterns within a developmental perspective. The pace of development in the first years is so rapid and the interrelationships among areas of development so complex that a young child’s experience of violence may re-emerge affecting the child’s ability to handle normal developmental challenges.

**Clinical Manifestations of Trauma in Young Children**

Some children exposed to violence are severely traumatized. Trauma has been defined as something that is outside the range of normal human experience and that involves a threat or actual assault on one’s physical integrity or the physical integrity of a significant other.

All trauma is in essence impossible to assimilate and therefore likely to interfere with learning and overall functioning. It is important to differentiate responses to trauma from other early childhood difficulties, which also interfere with a child’s growth and learning. Although trauma and deprivation both impact negatively on a young child’s development, they are not synonymous, nor do they necessarily manifest in identical ways.

A consensus seems to have evolved about the nature of symptomatology associated with traumatic phenomena in children and include re-experiencing the event, numbing of responsiveness, and symptoms of increased arousal. Teachers and parents observe changes in children’s behaviour and in children’s ability to learn in response to traumatic events. Together these symptoms, as described below, can indicate the presence of post-traumatic stress disorder (PTSD).

**Re-experiencing the event**

Victims re-experience traumatic events in dreams, flashbacks, intrusive memories and distress when confronted with reminders of the event. In young children, themes or aspects of the trauma are likely to be expressed in repetitive dreams and play. Children’s dreams reflect both cognitive processing of information and an effort to contend with life’s issues. Thus their dreams may provide an indication of what is left over from conscious over-processing during awake time. Dreams, like play, indicate the child’s attempts to gain control of events. For some children, their play, art, storytelling, and social interaction are laced with themes of the events.
Panic attacks and temper tantrums

When a traumatized child has a panic attack, he seems to become lost in a flood of anxiety. During the panic attack, the child may lose access to many of his ego capacities and/or experience bodily manifestations of his emotional crisis. The child might cry or scream inconsolably, tremble, hyperventilate, defecate, vomit, or sweat profusely. He might recoil into a fetal position, flail, repeatedly yell out a demand, or hit his comforter without seeming to realize her presence. Panic attacks might resemble ordinary temper tantrums, but should not be confused with them. Temper tantrums, which are part of the normal course of a young’s child development, are usually resolved in the context of the young child’s relationship with his caregiver. A temper tantrum may be seen to represent the child’s current struggle to resolve his rage at his caregiver for placing limitation on his freedom. In contrast, a panic attack in a traumatized child seems to involve the resurrection of old terrors. These terrors are associated with former traumatic experiences that may themselves remain unconscious. During panic attacks, children seem to lose their connection with others and become emotionally isolated. Panic attacks can be triggered by seemingly mundane events in a traumatized child’s daily life. A panic attack is usually not removed quickly and can continue for a long period of time until the child is simply exhausted.

Numbing of responsiveness

To cope with a dangerous environment, adults and children wear psychological blinders as protective gear. The process of desensitization includes both conscious and unconscious attempts to avoid all thought, activities and symbols of traumatic events, and thus avoid being flooded with the powerful feelings that come back when the traumatic events return. Though desensitization is a powerful survival strategy, the danger is spillover to other domains of social, emotional and cognitive development. The numbing response is also evident in children’s loss of interest in daily activities, and in their inability to remember or accurately recall aspects of the trauma. Some children react to trauma by using previously acquired developmental skills. They may begin to lose bladder control, suck their thumbs, and acquire speech problems.

Hyper−vigilance or symptoms of increased arousal

Paradoxically, along with numbness comes increased arousal. Sleep disturbances, irritability, an inability to concentrate, and an exaggerated startle response are observed among children who are exposed to traumatic events.

These children are perpetually on guard. They are anxious, wary and preoccupied with monitoring the environment for potential sources of injury and loss. Children of trauma have trouble modulating anxiety as well as aggression. Increased anxiety and generalized fears are common among traumatized children when they are confronted with reminders of frightening events.

Hyper−vigilant children are frequently assumed to have an attention deficit disorder since their activity levels are high and attention spans seem compromised. Yet it is important to note that the hyper−vigilant child is not deficient in attention per se, but rather is preoccupied by a never−ending watchfulness in order to ensure his own survival. In this way hyper−vigilant children are deprived of essential play, learning and social interactions. Children learn to screen out peripheral auditory stimuli and tune in to what is salient to them.

Play and the traumatized child

Trauma can alter the quality of the young child’s play in several ways. Some traumatized children are quite restricted in their range of play activities. Many traumatized children are initially unable to use play symbolically. Trauma may have interrupted developmental processes to the extent that symbolic capacities were not generated. Early relationships may have been disrupted, preventing the child from using transitional objects and other toys as symbols for significant people and experiences. Some traumatized children have developed symbolic capacity to a certain extent, but the quality of their symbolic play is quite unlike that of most young children. Gone is the sense of joyful adventure, story and spirited and imaginative discovery that is characteristic of childhood. The play of the remotest child is often grim and despairing. It tends to lack organization and elaboration. Disturbing themes might be introduced but never resolved in the context of play. Traumatized child’s play can become repetitive—the child is driven to play and replay his traumatic experiences in a compulsive attempt to master them. In addition, defenses against re−experiencing feelings associated with the trauma may be evident in the play. Any of these signs should alert the caregiver to the need for intervention.
Spiritual and Psychological Impact

Trauma also affects children’s underlying structures. The spiritual and philosophical symptoms of trauma include loss of security, general sense of loss and blurring distinction between friend and enemy.

Loss of security

In any society, children are the most powerless, and therefore the most vulnerable. Infants attach themselves psychologically to the adult caretaker who provides a safe base from which they can explore their surroundings. Within this relationship, children construct a personal representation of how life proceeds, developing a pattern of expectation for the future. What has been destroyed for children traumatized by war and violence is the idea of home, school and community as a safe place. The traditional places of safety have been destroyed by external violence. Danger replaces safety as the organizing principle. The essence of psychological trauma is the loss of faith that there is order and continuity in life. Trauma occurs when one loses the sense of having a safe place to retreat within or outside oneself to deal with frightening emotions or experiences. Following exposure to a traumatic event, the process of psychological healing is best aided by restoring a sense of safety and trust.

Loss of self

Loss is a significant theme in cases of trauma. One single event can result in any of the following losses − loss of people, loss of physical capacity, loss of protection, loss of control, loss of hope. With loss comes damage, trouble, disadvantage, and deprivation. Loss increases the child’s sense of vulnerability and can cause chronic sadness and depression.

Identification with the aggressor

To defend against the painful feeling brought on by traumatic experience, children will identify with the aggressor. In cases of physical or psychological abuse, abuser who traumatizes the child is often the person whom the child depends on for care and security. Identifying with the aggressor allows the child to maintain this alliance, however preserving it requires a great emotional sacrifice on the part of the child. By identifying with the aggressor, the child drives underground his own feeling of anger, fear and helplessness. He instead embodies the powerful aggression of the adult. The child may behave in an aggressive manner towards others, show little empathy, and seem to be disconnected from his own hurt and fragility.

Assessing Young Children Exposed to Violence

Professionals who evaluate young children exposed to violence should consider the following issues in order to determine if and what kinds of interventions are appropriate for the child:

Safety and stability of current living situation: This refers to the immediate threat of further violence? Can the adults regain trust in their community?

Age and developmental level of the child at the time of the trauma and the assessment: Special attention should be given to the infant's capacities for attention, anticipation, and symbolic capacities. Developmental milestones, such as toileting or expressive language, may be lost temporarily.

Quality of the pre–traumatic and current caregiving environment: Is there a supportive and emotionally available caregivers who is not too grief–stricken or traumatized to read and respond to the infant’s needs?

Type of violent event or circumstances experienced by the child: For example, did the event involve physical injury to the child and/or the caregivers?

Acuteness vs. chronicity of trauma: Was there a single event, or a series of repetitive events, or an enduring circumstance?

Actual and psychological proximity of the violent events to the child: Were people to whom the child is emotionally attached involved? Did the child witness or actually experience the events?
Post-traumatic and other symptoms in child and caregivers: Is there evidence of nightmares, post-traumatic stress or re-enactment play, and/or new fears in the child, or avoidance symptoms in the adult?

Strengths and protective factors in the infant and infant's caregiving environment: Which of these may prove useful in promoting adaptation? Is the young child able to play and talk openly about the trauma? Are caregivers able to reassure a fearful child without being overprotective?

Chapter 9 – Annex 2: Therapeutic Language: Talking with Distressed Children

A fundamental need of psychologically distressed and traumatized children is to connect emotionally with the adults around them. Some suggested ways language can help children and adults develop trusting relationships are described in this section.

Help the child understand the event.

Children need an explanation about what has been, and is, happening. They should know that there is a reason for the chaos and violence. They need to know that world has not gone insane, with people doing things in totally unpredictable and erratic ways. By giving them a political awareness of what is going on, children can be helped to frame the event in an important way and to feel more in control.

Provide the correct information.

It adds to the trauma when the child’s perception of reality is based on vague impression and fantasies about what caused the event and the consequences. A credibility gap will develop if children feel that something is kept a secret or if they feel that they are not properly informed. Honest, direct and tactful information is needed to enhance trust and understanding between children and adults. Follow the child’s lead and signals regarding his or her need for information. For young children, usually only a small amount of information is sufficient. Present it simply and in small amounts. Answer questions directly using words the child can understand. For young children, usually only a small amount of information is sufficient. Present it simply and in small amounts. Answer questions directly using words the child can understand. It is important to repeat the story as many times as the child wants to hear it. The child is likely to want the story repeated many times before she/he is really able to understand events.

Do not minimize the event; give children an understanding of the normality of their experience.

When children experience strong emotional reactions, and when images and thoughts continually return with intensity, children may fear they are going crazy and that they are not normal. It is important for adults to accept a children’s feelings without judgement, impatience, ridicule or teasing. To trivialize the event is not calming for the children, nor will it help lighten or relieve the trauma. Because young children think concretely, teasing or the ridiculing of feelings will lead to the belief that what they experienced was not real. If adults are respectful of the children’s feelings, they will be assured that what they experienced was real. It is helpful for children to know that their reactions are normal under abnormal conditions.

As an adult, share your feelings with children.

While adults may want to try to hide their feelings, the reactions of adults are frequently visible through their body language, which children are able to read. Thus, adults need to put their own reactions into words and make them explicit for the children. Adults also have to let children know that the children are not responsible for what the adult is feeling. Children have a tendency to see themselves as responsible for the negative and strong reactions of adults they love. This produces anxiety and guilt within the child. So, in addition to talking about their feelings, adults need to let children know that they are not causing the feelings.

Encourage children to express their feelings.

If adults are willing to share their feelings, then children can be encouraged to do so as well. It is important for children to express their feeling about their trauma. Young children experience a full range of emotions. However, few children – especially young children – are able to talk directly about their experiences or their feelings; they express their feelings through actions.

Give children words for their feelings.
While it is important for children to express their feelings through actions, in order to understand their feelings and to learn to feel in control of them, children also need to learn the words for their feelings. Children do not talk about their feelings, not because they do not have them, but because they do not have the vocabulary to recognize and distinguish feelings. As adults teach children to recognize their feelings, the next step is for the adult to offer the words to express their feelings. Being able to use words for feelings helps children work through their emotions; it allows children to communicate with the people around them and helps adults know what children feel. As children acquire language, they begin to use words and are able to express their thoughts and feelings verbally. Using words to describe emotions takes the power out of negative feelings and enhances positive feelings.

**Chapter 9 – Annex 3: The Healing Role of Play and Art**

Across cultures, children’s play involves the same themes – nurturing, family relationships and roles of people. Children seek to understand reality through play – there are no expected outcomes and children are free from failure. Through play, children are free to explore, invent and test possibilities. Children develop physical, social and mathematical knowledge in play. They find out how things work. In play, children experiment with numbers and construct ideas about the relationships between objects. Children at play are constantly at work – adding new observations, asking and responding to questions, and making choices. The insight gained provides children with problem-solving tools. Thus, play, in and of itself, is self-healing.

Children are able to deal with complex psychological difficulties through play. They seek to integrate the experience of pain, fear and loss. They wrestle with concepts of good and evil and express ideas for which they have no meaning. Children who live in dangerous environments play the dangerous environment. Children can take control of an event by playing different roles and altering the outcome. In symbolic play, children bridge the gap between reality and fantasy.

Children in situations of armed conflict have a special need for the freedom and emotional release inherent in play. Play–care settings can offer a rich physical environment that encourages individual as well as group play. Mobile play units or settings for children should contain building blocks, a water table and a dramatic play area. Time should be scheduled for drawing, storytelling, writing, games and music. The atmosphere needs to convey acceptance and respect for the children’s play. Play represents children’s innermost thoughts and feelings, and caregivers must be willing to accept all of them.

By providing the opportunity for play and art, caregivers can help children who live in dangerous environments address their complex feelings and concerns. The freedom of expression inherent in children’s playful activity and in their art needs the adult’s approval, permission, assurance, and support. Caregivers also need guidance, support and supervision to develop these important skills.

**Drawing and painting**

Like play, children’s drawing and painting is a spontaneous and deeply rooted activity. Drawings represent the child’s mental pictures and perceptions of the world. When given the opportunity, children all over the world enjoy drawing. When paper and crayons are not available, children use their fingers or a stick to scribble in the earth or snow.

Along with drawings of real events, children draw fantasies. When Palestinian children who have known no other environment than a barren refugee camp in the West Bank drew pictures, they added the flowers and butterflies they rarely encountered. For young children, the line between fantasy and reality is flexible. That flexibility may enable children to use play for emotional release, but it may also cloud their perception of environmental risk.

Adults understand that there are no monsters under the bed or in the closet at night, but children do not. Keeping real and imagined fears in perspective is a difficult task for young children. In their drawings, children give the adult a door to open. The door leads to conversations about experiences. Through these conversations, the adult can help the children find meaning that enables them to cope.

Although drawing and painting are beneficial for children of all ages, they are particularly useful for child whose language skills cannot convey the subtleties and intensities of their feelings. Children can obtain tremendous relief from drawing their fears and wishes. Children’s drawings can be used to elicit feelings and concerns on a one-to-one basis as well as in group settings.
Writing and storytelling

For most children, healing childhood stress and trauma depends on the strength of the adult–child relationships. Adults must be prepared to listen to children tell their stories on their own terms. The acceptance of the child’s reality is the starting point for the process of healing. “It is the permissiveness to be themselves, the understanding, the acceptance, the recognition of feeling, the clarification of what they think and feel that helps children retain their self−respect, and the possibilities of growth and change are forthcoming as they all develop insight” (Axlin, 1969).

A variety of writing and storytelling techniques can increase children’s opportunities to develop language and expressive skills. One method relies on verbal rather than visual images and allows a child’s imagination to create scenes of punishment and reward, anger and love. The storytelling format may use props such as family dolls, and sentence−completion exercises which provide children with an outlet for expressing in story form their responses to violence and armed conflict. Some additional activities include the following.

Bag–of−words game

This techniques can be used with individual children or in a group. The caregiver collects objects and places them in a bag. A child is asked to remove an object from the bag and tell a story about it. The facilitator can encourage children to discuss a particular topic by choosing the objects. The objective is to facilitate children’s expression of their inner feelings and concerns, and to explore the affective nature of events that occur in their lives (Gardener, 1975)

Squiggle game

In this game, a care giver makes a squiggle mark on a piece of paper and gives it to a child. The child is asked to make a picture from the squiggle. Upon completion, the teacher asks the child to tell a story about the drawing. From the child’s story, the teacher learns the theme of the child’s thought and can identify the effect attached to the story. Using the child’s lead, the teacher asks the child to draw a squiggle, which the teacher completes. In creating a story, the teacher can offer alternative outcomes to the child’s story in an effort to help the child understand his feelings.

Puppets

In the hands of a creative and responsive adult, puppet play offers an ideal arena for playing out difficult themes and issues. Puppets provide children with an outlet for feelings of helplessness while at the same time providing the possibility of problem solving.

Dolls

The young child who fears danger may try to master this fear through doll play that enacts scenes of comforting and nurturing. The child identifies with the doll that is comforted, thus simultaneously permitting expressions of the fear and its resolution. Doll play frequently takes the form of the child simultaneously identifying with both baby and nurturer.

Clay

The possibilities of doing and undoing implicit in the medium of clay make it useful for symbolic acting out of aggressive impulses and identification with the aggressor. It offers the child a fantasy means of controlling the outcome.

Board games

The competitive aspects of many board games lends special significance to their use with children responding to the stress of war. While winning and losing is always an issue for children, the role of winner takes on special significance during times of conflict when children have a heightened sense of right and wrong, winner and loser.
Chapter 9 – Annex 4: Building Resilience: Implications for Programmes

“There is a regrettable tendency to focus gloomily on the ills of mankind and on all that can and does go wrong. It is quite exceptional for anyone to study the development of those important individuals who overcome adversity, who survive stress, and who rise above disadvantage. It is equally unusual to consider the factors or circumstances that provide support, protection, or amelioration for the children reared in deprivation. This neglect of positive influences on development means that we lack guides on how to help deprived or disadvantaged children. It is all very well to wish for the children to have a stable family which provides emotional support, social stability, and cognitive stimulation. But we are almost never in a position to provide that. Would our results be better if we could determine the sources of social competence and identify the nature of protective influences? I do not know, but I think they would. The potential for prevention surely lies in increasing our knowledge and understanding of the reasons why some children are not damaged by deprivation” (Rutter, 1979).

“Resilience is the human capacity to face, overcome and be strengthened by or even transformed by the adversities of life. Everyone faces adversity, no one is exempt. With resilience, children can triumph over trauma, without it trauma triumphs” (Grotenberg, 1995).

While the developmental consequences of living in chronic violence can be devastating, not all children exposed to powerful stressors sustain development damage. Some children develop a high degree of competence in spite of stressful environments and experiences. What is resilience? Who are these ‘resilient’ children? What protects them from the damaging effect of day−to−day violence and victimization? Can these protective mechanisms be understood and used to enhance programme interventions?

A child's individual characteristics and early life experiences, as well as the protective factors in the child’s physical and social environment, contribute to resilience. These characteristics can buffer a child’s response to constitutional risk factors or stressful life events. The following section describes the way these factors operate.

Age and Character Traits of Resilient Children

The age and characteristics of the child have a mediating effect on how well the child survives. Physical health plays a role since a strong healthy child is more likely to be emotionally and psychologically resistant. A child’s reaction to violence depends on the child’s age and developmental maturity. Older children are better able to cope with stress than younger children, as the increasing cognitive maturation enhances expression and coping.

Research has reported a series of individual characteristics that lead to resilience including cognitive competence, experiences of self−efficacy, and a corresponding self−confidence and positive self−esteem. Resilient children are active, affectionate, good−natured and easy to manage. They generate a high degree of attention and warmth from their caregivers. These traits, which are developed in early childhood, can buffer children from severe stress and trauma.

Others have observed that resilient children are able to manipulate and shape their environment to deal with its pressures successfully, and to comply with its demands. They adapt quickly to new situations, communicate freely, and act flexibly. Compared to vulnerable children, they are able to tolerate frustration, handle anxiety and ask for help.

Resilient children have the capacity to make sense of the stressful and traumatic events confronting them. This representational competence—the ability to understand what is occurring—helps children master the stress. The ability to make sense of threatening experiences is a crucial skill and a fundamental of principle of successful ECD intervention programmes.

Protective Environments

Stress is more likely to lead to growth, rather than to defeat, if the child is in a predictable physical and social environment. A number of protective factors in the child’s family, community and cultural ideology have been identified in buffering stress and trauma for children.
The role of families

Consistent caregiving and secure attachment relationships between the child and the primary caretaker contribute to resilience. The quality of the attachment relationship differs according to the quality of the care the infant receives. The knowledge that a caregiver is accepting, sensitive, available and responsive gives the child a strong feeling of security and confidence and contributes to resilience. The attachment relationship is a potent determinant of the child’s social, emotional and cognitive development. Strong early attachment can buffer much of the trauma of loss. The ability to recall earlier positive experiences with their parents is an important buffering factor for older children. The idealization and identification with parental and cultural values act as a protective factor. Thus, resilience becomes internalized.

Resilient children have parents who are ‘models of resilience’. During adversity they are available with reassurance and encouragement, helping their children understand and process stress and trauma. Parental resilience tends to predict child resilience. The security of parents has the potential to compensate for traumatic impacts. Because they do not fully comprehend inherent danger, younger children often exhibit only minor symptoms of anxiety when they are able to remain physically close to at least one parent and when parents are able to remain calm themselves.

Other family members can also protect a child from developmental harm. The extended family can lessen stress, encourage coping behaviour, and facilitate the child’s ability to work through stress and trauma by providing additional adult nurturing and positive role models.

Promoting Resilience

A thirty−nation study of resilience and how it develops, identified three sources of resilience that children draw upon in overcoming adversity – I HAVE, I AM, and I CAN. The I HAVE category represents the external supports that provide children with security and feelings of safety. The I AM category describes who children are in terms of their internal sense of self and how they present themselves to the world. The I CAN category refers to the ways in which children relate to the world. This dimension includes the child’s social and interpersonal skills (A Guide To Promoting Resilience in Children: Strengthening the Human Spirit, Grotenberg, Edith, 1995).

I HAVE:

- people around me I trust and who love me, no matter what
- people who set limits for me so I know when to stop before there is danger or trouble
- people who show me how to do things right by the way they do things
- people who want me to learn to do things on my own
- people who help me when I am sick or in danger or need to learn

I AM:

- a person people can like and love
- glad to do nice things for others and show my concern
- respectful of myself and others
- willing to be responsible for what I do
- sure things will be all right

I CAN:

- talk to others about things that frighten me or bother me
- find ways to solve problems that I face
- control myself when I feel like doing something not right or dangerous
- figure out when it is a good time to talk to someone or to take action
- find someone to help me when I need it
The Role of the Community

The community must sustain the basic infrastructure of family life, including parent and child attachment, parental self-esteem and identity, and stability of routine caregiving arrangements. Social support plays a powerful role in the resilience of children. Children need coherent experiences and the help of concerned, competent adults to meet new demands, to cope with new stresses, and to achieve new levels of development. The child’s perceptions that some social networks are able to maintain care and protect affects the degree of stress experienced. Social support systems that act as potent protective factors in the lives of resilient children are friends, neighbours and teachers. They provide emotional support, incorporate self-esteem, and promote competence. Social support in the form of a socially coherent community can do much to enhance the resiliency of children.

Community influences go beyond the interaction of the child with individuals from the community. They also affect the degree of support and guidance given to parents so that they can become effective partners in the child's development. Community factors influence whether or not parents adopt an ideology that provides philosophical, moral, spiritual, and political support for the active coping that helps children develop and express resilience. Community influences are important in providing the open, supportive education climate that is itself a source of resilience for children. Communities can do much to set the tone and the content of individual parenting decisions. The cultural blueprints provided for school – curriculum, ambiance and the like – can translate into a setting for children that encourages active processing.

The Role of Ideology

Ideology can also explain the resilience of families and their ability to buffer stress for their vulnerable young children. Ideology is a psychological resource that contributes to resilience by giving substance and meaning to dangerous events. It sustains the ability to function under extreme conditions. Political and religious views, especially when they are held with extreme intensity, can shape the consequences of experience. Strong religious beliefs in families have brought stability and meaning to children's lives, particularly during times of hardships and stress. They give children a sense that conditions are not hopeless, that changes could occur, that they will be protected.

The socialization practices that exist within a culture before the violence will determine to some degree how children respond as a result of the violence and what they need to thrive. Cultures have different ways of socializing children and different attitudes and beliefs about what constitutes appropriate behaviours. In designing intervention strategies, it is important to know the extent to which there are coping strategies in the culture and what they are. It is important to be aware of and work with socialization practices rather than against them.

The impact of violence on the behaviour of young children, must be based on a framework that recognizes the relationship between risk and resiliency. Only then can appropriate interventions be identified.

Chapter 10: Young People, with a Focus on Adolescents

Rationale

Conflicts, crises, and complex emergencies affect the development of young people in a number of ways. The devastation of educational, vocational and other basic services deprives young people of years of care and training, and creates generations of unskilled and unemployable populations. Extended social, political and economic turmoil affects the social fabric and culture of families, households and communities, all of which are so important for adolescents’ development. The economic collapse and slow deterioration of States in
crisis and the consequent lack of livelihood opportunities force many young people into a culture of violence, and even a life of crime. Their unaddressed needs and squandered potential seriously undermine their abilities to contribute positively to stability and state reconstruction. Young people are more easily exploited where violence is the norm and there is little hope in the future, and the social disruption that occurs in such situations has serious implications for their health and development, HIV/AIDS being a notable example.

A neglected group

General Aim

In situations of armed conflicts and complex emergencies, UNICEF aims to ensure that the specific rights of adolescents and other young people are protected: their rights to develop their capacities, to have access to a range of services, to live and learn in a safe and supportive environment, and to participate.

A significant part of international human rights law, including the 1989 Convention on the Rights of the Child (CRC), is based on the protection of all children, which in terms of the CRC, includes all young people up to the age of 18 years. However, much humanitarian assistance and protection in armed conflicts is targeted at younger children, especially under-fives. Although some aspects of emergency programming in armed conflicts and complex emergencies do address the concerns of adolescents, such as child combatants (see Chapter 12), the psychosocial impact of armed conflict and reproductive health, by and large their needs are not distinguished from those of younger children, and the needs of older adolescents and youth are not distinguished from those of adults. The reasons for this are several:

- The youngest children are seen as most at risk of disease and mortality in armed conflicts, famines and early stages of displacement. In reality, adolescents are not only exposed to common endemic diseases but may also be particularly at risk in countries with a high prevalence of HIV/AIDS, which would include most countries in sub-Saharan Africa, or in situations of chronic deprivation, such as Southern Sudan.

- Young people are physically more resilient, more knowledgeable and less dependent. Although they are seen as more able to fend for themselves than younger children, this is likely to be a time when they are particularly in need of the support and guidance of parents and other adult duty bearers who are usually not available in emergencies.

- Many adolescents are active participants in armed conflict. As perpetrators of violence, they are often perceived to be a threat, yet as a group, they are in need of protection and care, and are likely to play a key role in future reconstruction and reconciliation. Cultural definitions of childhood vary and the dividing lines between childhood, youth and adulthood are often ambiguous. The CRC focuses on children up to 18 years old, but clearly young people 18 years and older have an important influence on the cohort immediately behind them.

- An additional problem is that when young people do receive attention they are thought of as problems rather than as an important resource/asset to be developed. In complex emergencies young people have much to contribute; apart from anything else they are frequently responsible for fulfilling and protecting the rights of small children, as caregivers and too often as parents.

A critical stage

Psychologically, children’s capacity to function effectively within their society is determined by their life experiences. Adolescence is a critical stage in the psychological and physiological processes of development. Furthermore, adolescents who are severely malnourished or under extreme stress face many of the same risks for disease and infection as younger children. They also have unique health and psychosocial needs that require special attention.

- The growing cognitive maturity and ability of adolescents to understand their violent environments brings greater risks of psychosocial problems than it does among younger children.

- Adolescents’ sexual development and their relative immaturity and inability to resist adult pressures puts them at greater risk from sexual violence and abuse, HIV/AIDS, other sexually transmitted infections (STIs) and other consequences of unwanted and unsafe sex.
• Those who have participated in hostilities can be marked for life – mentally, morally and physically. It can cause them to be ostracized, making them social outcasts at an age when this is particularly devastating.

• Sexually abused girls (and boys) may not be accepted back into their communities.

• The adult-like behaviour of adolescents can mean that they are neglected by caregivers and no longer receive the basic nurturing they may still need.

• Their need for intellectual, psychological, physical and social stimulation can be overlooked by responses that focus solely on food and health. In general, humanitarian assistance focuses more on death and disease than it does on meeting the psychosocial needs of people in conflicts and complex emergencies, particularly important for adolescents.

• They are entering a transitional period into adulthood, where independent participation and self-expression in the world around them is not only feasible and demanded by young people but is their right; they can make an important contribution to their communities if given the skills, the opportunities and the support, and this in turn contributes to their own development and protects them from high-risk behaviours.

For some adolescents, the disruption to the process of identity formation and the capacity for dealing ‘pro-socially’ with aggressive or sexual impulses, the loss of guardians and role models in the family, and the inversion of societal and cultural values can manifest itself in aggressive and delinquent behaviour, substance abuse, depression and suicide.

A Strategic Population

Youth and adolescents are strategically important groups that need to be incorporated into mainstream emergency programming.

Adolescence is when children develop roles and responsibilities, and incorporate into their lives the values and norms of their societies. Armed conflict and other emergencies disrupt this process. Young people are not only physically displaced but are also dislocated from their social environment. This can disrupt the continuity of instilling social values and norms for the future of the whole society.

Many conflicts last a whole childhood, and young people who grow up surrounded by war and conflict can be socialized into a culture of violence. As the next generation, this has implications for future stability. Peace, reconciliation and post-conflict reconstruction processes must involve adolescents and youth if they are to be successful. But in order to contribute, these young people must have the necessary information and skills, and adult support.

Young people constitute a substantial and growing proportion of the population of many less developed regions. The majority of armed conflicts and complex emergencies are occurring in the least developed regions, and adolescents and youth make up a significant proportion of those war-affected populations. Between one quarter and one half of all refugees are children under 18 years old and of these 80 per cent are between 5 and 18 years. Adolescents constitute at least 20 per cent of the population in most countries in sub-Saharan Africa and South Asia.

There is a critical need to protect adolescents and youth from exposure to neglect and violence. The physical, psychological, social and political rights of young people must be protected to assure not only their health and well-being, now and in the future, but also the health of the next generation and the future of the society at large.

Marginalized and disaffected youth are a significant political force. Neglected by the State, their aspirations unmet as economic decline closes down educational and economic opportunities, the uneducated, unemployed and socially excluded youths may become a politically volatile population, more open to manipulation and high-risk behaviours.

Unlike younger children, adolescents and youth often become active ‘participants’ as well as ‘victims’ in war. In West and Central Africa alone, it is estimated that there are between 20,000 and 50,000 child combatants. The majority are between 10 and 14 years old. In Liberia, Mozambique, Sierra Leone, Somalia,
Sudan and Uganda, adolescents make up a significant proportion of fighters in the military factions.

**Adolescents and youths are an essential resource for the survival of families and younger children.** Most are caught up in wars as civilians rather than combatants. They often play an important role in the care of young children, and can become active participants in relief, recovery and reconstruction efforts.

**General Aims and Strategies**

Outcome 3 of the future global actions for children focuses on adolescents, the goal being to ensure that they **have opportunities to fully develop their individual capacities in safe and enabling environments and are helped to participate in and contribute to their societies.**

The overall programming and policy framework that is being promoted to achieve this overall outcome, around which there is strong consensus with a range of UN and NGO partners, focuses on fulfilling and protecting adolescents’ rights in four main areas:

- their rights to develop their capacities, through information, life skills, livelihood skills, etc.
- their rights to have access to a range of services and opportunities, including education, health services and recreation
- their rights to live and learn in safe and supportive environments, to be protected from exploitation and abuse
- their rights to participation in decisions that affect their lives, to be able to contribute

Adolescence is a period of the life-cycle that provides us with opportunities to intervene in many vicious cycles that undermine human rights and development. In conflict situations and complex emergencies this may be particularly important since many of the causes of inequity and injustices, such as gender or ethnic discrimination, tend to be reinforced. This makes it a particularly important period to focus on, not only for the present but also for the future.

During the past decade there has been growing attention paid to adolescents, including adolescents in conflict situations and complex emergencies, by NGOs and UN organisations (see for example the publication by the Women’s Commission for refugee women and children, *Untapped Potential: Adolescents affected by armed conflict*, the work by UNHCR, UNFPA and partners focusing on the reproductive health care of refugees and displaced populations, and the adolescent component of the training modules developed for the UNHCR/ISCA Action for the Rights of Children.

For each of the areas outlined in the future Global Actions for Children, there are examples of initiatives taking place in complex emergencies and conflict situations that focus on adolescents: providing young people with information and access to sexual and reproductive health services; increasing adolescents’ access to education programmes; providing young people with safe and supportive environments through protection efforts directed to sexual exploitation, conscription, and the reintegration of child soldiers; and involving young people in the decisions that affect their lives, such as the programmes with youth that were developed with the refugees from Kosovo. Additional examples are included in Annex 1 (Safe Places for Young People).

There are a wide range of entry points for focusing on adolescents, including the transmission of HIV and the impact of AIDS among/on adolescents, violence, abuse and exploitation of adolescents, adolescent heads of household, adolescent nutrition, and a range of protection issues. Strategies to fulfill and protect the rights of young people in conflict situations need to include a focus on the following:

- Raise general awareness among warring parties, community leaders, youth and civil society organizations about the Convention on the Rights of the Child, the Geneva Conventions and other international human rights instruments as they pertain to all children up to 18 years of age.
- Identify the social, economic, political and cultural factors that influence the vulnerability and participation of adolescents and youths in armed conflict.
- Promote and support policies and activities that address their protection and welfare needs, with particular attention to the needs of adolescent girls.

Document violations of the rights of adolescents and youths, and advocate with government and non-government entities against violations, such as the military conscription of adolescents, and for the rehabilitation of adolescent combatants (see Chapter 12, Child Combatants).

- Support the development of appropriate legal and institutional frameworks for juvenile justice dealing with adolescents and youth accused of war crimes (see Chapter 13, Children in Detention).

- Support physical and psychological programmes for war-affected adolescents and youth.

- Promote the participation of young people in the design and implementation of programmes that address their needs for protection and care.

- Include explicit attention to adolescents in the provision of basic social services, such as education and health, and in food security programmes.

Basic Principles

The CRC, the Geneva Conventions and other humanitarian and human rights instruments provide the guiding principles for UNICEF’s work with adolescents and youth in armed conflicts and emergencies. The collapse of state authority in many countries gives the international community greater responsibility for the protection and welfare of children of all ages, to ensure that all parties uphold these principles. The following are key considerations in working with young people.

Understanding strategies of warfare: Understanding the nature of armed conflicts, contemporary strategies of warfare and the way in which they impact on societies is a prerequisite for the effective humanitarian protection, care and rehabilitation of adolescents and youth.

Vulnerability: The vulnerability of youth and adolescents in armed conflicts arises primarily from being children of a particular socio-economic, political, ethnic or religious group. Political vulnerability is a key determinant in the survival of any group. The protection of young people, therefore, needs to be integrated with wider human rights advocacy. Vulnerability is deepened by attacks on civil and civic institutions, such as the family, traditional authority structures, as well as state welfare institutions and services. Attention needs to be given to sustaining social structures and institutions, as well as individuals. Protecting a ‘way of life’ is critical to protecting individual lives.

The Graça Machel Report entitled ‘Impact of Armed Conflict on Children’ identifies adolescents as a ‘neglected group’, and recommends that:

UNICEF should accelerate the development of programming for adolescents which:

- include opportunities for their participation in programme design, implementation and evaluation

- reflect the importance of education, sport and recreation in adolescent recovery and development

Perceptions of childhood: Cultural perceptions of childhood affect local responses to the needs of adolescents and youth. It is important to be aware of cultural perceptions of childhood and youth, including the social and economic responsibilities of young people, and the cultural rites and ceremonies related to growing up and becoming an adult.

Understanding adolescent development: Despite the heterogeneity of adolescents, in terms of age, sex, marital status, and other characteristics, this is a period of rapid physical and psycho-social development, with changing roles and relationships, evolving capacities and expectations, and new privileges and responsibilities.
Understanding protective (and harmful) traditional practices: In some societies the transition to adulthood is marked by initiation ceremonies, and before such ceremonies, children are protected from adult obligations. In southern Sudan, for example, children were once prohibited from going to fight in armed conflict until after their initiation into adulthood. Initiation formerly took place between the ages of 16 and 18, but with the absence of many adult men, the age of initiation has fallen – sometimes to as low as 12 or 13 years old. This has had implications for the protection of children from under-age recruitment, since in the eyes of the community, they are already adults.

Addressing practical needs: Young people have immediate practical needs for skills, education, health services, income generation, and recreation. Emergency programmes need to develop the means to meet these needs, in safe environments.

Participation of adolescents and youth: The CRC protects the right of children to self-expression. The skills, ideas and creativity of young people should not be neglected. Actively involving adolescents and youth in relief and reconstruction efforts can have therapeutic benefits by giving them a sense of meaning and purpose, and by providing them with structure and adult support.

Community-led process: Strengthening family and community-led activities to support the needs of adolescent-headed households, young mothers, child soldiers, and the psychologically harmed will assist in rebuilding the social fabric, trust, responsibility, security, and societal norms.

Defining Youth and Adolescence

Vulnerability and need will vary according to different stages of the life-cycle of the child. The needs and experiences of a 10-year-old will differ significantly from those of a 17-year-old, similarly there are usually significant differences between the experiences and expectations of boys and girls. Married adolescents may likewise have different needs and require specific attention.

Globally, the idea of the child as a person under 18 years old enjoys wide support. The CRC (Article 1) defines the child as “every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier.” Eighteen is generally accepted as the age of legal majority, when a person attains the legal rights of an adult. Around the world, 18 is the accepted voting age, when a society recognizes the intellectual maturity of the individual. Eighteen or older is also the legal norm for military conscription.

These distinctions are inherently challenging in determining needs and humanitarian responses, because conditions of childhood and children’s needs shift so dramatically in emergency situations. The CRC does not differentiate ages and stages of childhood. Adolescents and youth above 18 years old are by definition not protected by the CRC, although of course they continue to be protected by other human rights instruments. Definitions of childhood affect the provision of humanitarian care and protection for all children, including adolescents. Although few adolescents want to be called ‘children’, defining them as such reminds governments and civil society that adolescents remain dependent on adults to fulfill and protect many of their rights to development and health.

Definitions of stages of childhood do not always transfer across cultures: The age at which societies separate childhood and adulthood and assign legal responsibilities to individuals, such as for marriage purposes, varies between cultures. In some societies communal ceremonies initiate children of different years into the same ‘age-sets’. Some cultures do not consider a person fully mature until they have a child. In many countries the term “youth” would include people in their 30’s.

Definitions influence demographic information: In Sierra Leone, young people under 18 years of age make up 60 per cent of the population. In Namibia, youth under 30 years old make up 78 per cent of the population. The difficulty of defining who are adolescents and youth by age is exacerbated by the lack of birth certification.

Children do not grow up equal: Experiences of childhood differ according to a variety of factors. The ability of children to cope with risk and stress is not only determined by age and physical strength, but by other factors such as gender, socio-economic class and ethnicity.
Childhood for many is not a period of innocence: Seeing children exclusively as ‘dependent’ and ‘victims’ – a view implicit in the notion of children as ‘zones of peace’ – owes much to a Western historical and cultural construct. The reality of children as perpetrators of violence in war challenges this prevailing view.

In war, families are often restructured by displacement and death: The ‘social upheaval’ caused by armed conflicts impacts on marriage, child-bearing age, work and decision-making responsibilities. Children are forced to take on roles that challenge definitions of childhood. In Cambodia, Mozambique and Sierra Leone (where a recent head of state was only 26 years old), the reversal of adult and child authority roles has been a common occurrence.

Organizational concerns influence needs assessments and analysis: This in turn can influence the definition of adolescents and youth, the crisis affecting them and the way that emergency responses are conceived and implemented. Medical and health information on children in war is routinely collected, but is often poorly targeted by age, gender or other factors. An organizational concern with specific ‘categories’ of children, such as under-fives, can mean that numbers of children registered and assessed may bear little relation to total numbers of children in need. Youth and adolescent needs can get passed over completely. Information on the suffering of individual children drive responses based on individual needs, rather than on wider social and structural needs.

Welfare practices defining children as vulnerable and dependent tend to emphasize custodial care and institutional models of assistance: Universal models of childhood, which characterize children as passive victims rather than active survivors, can mean that their resilience and capacities, and the productive roles that youth perform in the family and community, are overlooked. In cultures where children are viewed as active and economically productive members of the community, strengthening community or extended family support may be more appropriate.

Field-Level Strategies

Prevention strategies

A stated humanitarian goal of UNICEF in conflict-generated emergencies is to prevent the exposure of children to risks by addressing the root causes of conflict.

In pursuit of this goal, UNICEF should seek to comprehend the linkages among the root causes of armed conflict, young people’s participation, and the impact of armed conflict on adolescents and youths. Understanding these connections and intervening before the fact is the best hope of preventing both participation and harm.

Strategies of warfare and the nature of youth violence

Understanding contemporary strategies of warfare is important for developing appropriate prevention, protection, welfare and rehabilitation programmes. Insurgency and counter-insurgency strategies commonly aim to destroy the social fabric of society by targeting the family, home, and community as a means of controlling populations. The destruction of social institutions, political structures and societal norms is often a deliberate strategy of war.

Situational analysis

UNICEF’s country situational analyses need to incorporate an assessment and analysis of adolescents and youth as strategic population groups. UNICEF’s stated concern for equitable development, marginalized populations, equal opportunity, legal protection and education should incorporate planning ahead for the rights and needs of adolescents and youth in conflict situations and complex emergencies. Every attempt should be made to listen to and involve adolescents and other young people in the situation assessment and analysis, and to focus not only on the problems but also on the potential of young people as a resource.

Preventing adolescent combatants

Preventing recruitment will happen most effectively if there is an understanding of the motivations for young people volunteering or allowing themselves to be conscripted. Motivations will vary according to personal experience, community expectations or peer pressure. For some, the motivation will lie in the social, economic
and political roots of the conflict. For some, participation in violence becomes a medium of empowerment for young people. It has been noted that media violence is both used for instruction and as a source of ‘inspiration’ for youths.

The determining factor in recruitment – voluntary and involuntary – is not age. It is membership in a particular socio-economic class, or ethnic, religious, clan or kinship group. In armed conflicts, it is the children of the disenfranchised, illiterate and poor families least able to provide protection who are most vulnerable to recruitment. A particularly disadvantaged group are the inhabitants of refugee or internally displaced camps. The fact that it is the poorest, least educated and most disadvantaged who are the prime targets of recruitment, refutes arguments for a lower age for recruitment, or that the participation of youth is ‘culturally acceptable’.

To be meaningful, it is imperative that prevention strategies recognize the forms of social and economic injustice and the forces of structural oppression, inequality, discrimination, and racism within societies. It is necessary to strike a balance between considering an individual’s needs and considering those of the group they belong to. Only by confronting these larger issues can one realistically prevent the participation of adolescents in war, or ensure the effective demobilization of child soldiers.

Strategies for Protecting the Rights of Adolescents and Youths

The principal goals of all UNICEF emergency programming are:

- prevention
- protection
- amelioration
- rehabilitation
- recovery and long-term solutions

Together, they provide a framework for field-based strategies to address the needs of young people.

Whether victims or participants in armed conflict, adolescents are entitled by international humanitarian law to protection from harm and appropriate care. UNICEF’s humanitarian response to the needs of adolescents and children in armed conflicts must combine protection with a service-delivery function. That is to protect children from harm and to protect the humanitarian imperative. Raising standards of protection for young people should include the following interrelated strategies.

Protection from recruitment

The recruitment of adolescents and youth by armies is not a new phenomenon. What is new and disturbing in many contemporary wars is the recruitment of adolescents. Young people are very vulnerable to recruitment. Those above 18 years of age fall outside the general protection of the CRC, which at present officially limits conscription and recruitment to above 15 years old only. In May 2000, the General Assembly adopted the Optional Protocol to the CRC, which establishes 18 as the minimum age for participation in armed conflict, for any compulsory recruitment, and for any recruitment or use in armed conflict by armed groups.

All States are bound by the rule that no child under 15 shall be recruited into the armed forces. Compliance is clearly problematic, given the prevalence of children in the armed forces of government and non-government entities. While the optional Protocol calls on governments to raise their minimum age for voluntary recruitment to 18, it also allows governmental armed forces to accept voluntary recruits from the age of 16, subject to certain safeguards. A core protection issue must be to advocate with all warring parties for raising the legal age of recruitment into armed forces to 18 years (see chapter 12). Other measures to improve compliance should include the following:

Reporting: The routine monitoring and reporting on abuses of under-age recruitment should form part of UNICEF’s humanitarian response in an armed conflict.

Dissemination: Article 42 of the CRC obliges State Parties to “make the principles and provisions of the Convention widely known, by appropriate and active means, to adults and children alike.” As such, it is necessary to explain to warring parties why all children under 18, even when performing adult activities, are protected by the CRC. Young people themselves are a critical audience for the dissemination of information on their rights.
Most adolescent combatants are not conscripted or forcibly recruited into armed forces. Most are forced by circumstances into enlisting voluntarily. Strategies to prevent recruitment and to protect youth and adolescents from coercion need to comprehend the push–and–pull factors behind young people taking up arms.

Educational deprivation is the hallmark of the child volunteer.

Inter–agency collaboration: An advocacy strategy can draw on support from other agencies. UNHCR, for example, can be co–opted to help influence policy and practice in protecting refugee adolescents and youth from recruitment and participation.

Traditional codes: In many societies, children, young people and women have been traditionally protected in war by codes of conduct. In Sudan, through Operation Lifeline Sudan, UNICEF has drawn on such traditional codes of warfare to advocate against under–age recruitment and to explain the CRC. The International Federation of the Red Cross and Red Crescent Societies have taken a similar approach to disseminating the Geneva Conventions in Somalia, where violence against women and children was traditionally prohibited to ‘ensure the survival and continuity of the family’.

Gender–based violence

Special attention is required to protect adolescent girls from sexual violence and exploitation in all settings – at home, in flight or in displaced camps. As with children in general, their level of vulnerability to violence is mediated by their ethnicity, class, religion or nationality. Rape of adolescent girls can even be a deliberate policy of warring parties. Sexual violence against adolescent boys is underreported, and a focus on adolescent boys and young men is important in terms of their socialization into gender–based roles as warriors, defenders and soldiers.

Sexual violence contributes to many health and social problems among adolescents and youth:

- Adolescent girls, and also boys, who are particular targets of sexual violence, are at risk from sexually transmitted diseases (STDs), including HIV/AIDS.
- The breakdown in social values and controls, as a result of war and displacement, can also make sexually active adolescents prone to STDs and HIV/AIDS.
- Adolescent girls are particularly vulnerable to infection and diseases, both in terms of their socio–cultural discrimination and disadvantage and also because of biological vulnerability.
- Pregnancy complications can affect a girl’s future childbearing as well as her health and that of her children.
- The health and well–being of adolescent mothers and adolescent heads of household is critical to the lives of their children.

Access to reproductive health services, including education, for adolescent girls is crucial. Their protection and care is essential (see chapter 11, Sexual Violence).

Family and community protection

The rights of the child are best protected, and their survival and development best assured, through the family. Where the vulnerability of populations arises from the deliberate targeting of civil and civic institutions, measures to sustain family and community units and welfare structures and services will be an essential strategy in the protection of adolescents and other young people during armed conflicts. While recognizing the centrality of the family and the community in the recovery and protection of children, the needs of adolescents and youth must be distinguished from those of younger, more dependent children.

Juvenile justice

In many countries, adolescents and youth are routinely detained by authorities concerned about their links with opposition forces. Young people accused of treason, war crimes and other activities deemed criminal are entitled by the provisions of the CRC (article 40) to be treated with dignity and justice, according to the due processes of law. This is necessary for their own personal rehabilitation and in order to sustain or re–establish moral and social norms. Advocacy should emphasize rehabilitation rather than retribution, while taking into
account the age of children and sensitivities of local communities to their crimes (see Chapter 13, Children in Detention).

**Human rights advocacy**

A key constraint to protection of children is their political vulnerability because of their tribal association, class, ethnicity, or religion. In Bosnia, it was Muslim children rather than children per se who were targeted by snipers. In Sudan, it is Dinka or Nuba youth that are targets of government military recruitment, re-education campaigns or slavery. In Sierra Leone, young combatants are drawn from the rural areas and poor urban ghettos. In Somalia, clan militias were recruited from young nomads and unemployed urban youth. To be effective, universal campaigns to protect youth must be based on an analysis of their vulnerability and integrated with wider human rights advocacy.

**Providing for the Rights of Adolescents and Youth**

Humanitarian assistance should be appropriate to assessed need. This will require the service needs of youths and adolescents to be distinguished from those of younger children.

**Education**

The CRC (article 28) obliges signatories to ensure that the child’s right to education is achieved “progressively and on the basis of equal opportunity.” Education is now recognized as a priority component of humanitarian assistance (see Chapter 3, Ongoing Education).

The destruction of educational and vocational training services in war will leave a population of uneducated and unemployable adolescents and youth reliant on a war economy and criminal activities. When educational deprivation marks a child, an illiterate and unskilled population will be an obstacle to reconstruction and stability.

Emergency education programmes mostly focus on primary education. Teacher Emergency Packs developed by UNICEF and UNESCO are designed for primary school children up to 12 years old. Emergency educational packages appropriate for adolescents and secondary-level education need to be considered, although it needs to be appreciated that a large percentage of children in primary schools in disadvantaged communities are adolescents.

The difficulties of providing education for adolescents and youth during armed conflict are formidable:

- Education is no panacea to violence. In many armed conflicts, it is often the educated who take a lead in directing the violence.

- Adolescents and youth may reject the importance of education on the grounds that it delays entry into adulthood, lengthens childhood dependence and does not guarantee employment. Soldiering can bring more immediate material benefits.

- Education is not free from ideology. Authoritarian education systems and ‘re-education’ programmes can be oppressive and manipulative. Schools can be targets for the recruitment of young people.

- Cultural restrictions can affect educational opportunities for girls.

Different strategies must be tried:

- Decentralized informal education provides flexibility, but monitoring the quality can be problematic.

- Education may be more attractive and relevant to young ex-combatants if emphasis is placed on vocational skills and livelihoods.

- Distance education, utilizing the medium of radio, may be appropriate for adolescents and youth in inaccessible areas.
Peer education and child–to–child approaches have potential for informal education.

For combatants whose level of schooling has dropped behind younger children, there need to be opportunities for ‘second chance’ or ‘catch–up’ education.

Tertiary education may be of particular interest to refugee and displaced populations, who will need skills necessary for social and economic reconstruction on returning to their homeland.

Education is important:

- for psychosocial development and well–being;
- to keep adolescents from military service and other forms of exploitation;
- to prepare young people to take an active part in the recovery processes.

In all cases, there should be opportunities to add safety skills and child rights education to the school curriculums. Post–conflict realities may set new priorities. A national literacy campaign or tertiary education, for example, may be more of a priority than simply re–establishing the former system.

Health care

Article 24 of the CRC states that children under 18 have the right to the highest standards of health and medical care. Emergency health care is generally targeted at children under five years old and at mothers. Special provision is needed for young people, taking account of their specific health needs, such as reproductive health.

**Young female–headed households and young mothers require special assistance in health care:** WHO advocates that reproductive health services based on women’s needs should be available in all circumstances. Adolescent girls are more likely to suffer complications in pregnancies; and when families are separated, young mothers will lack the maternal support they would normally receive.

**Gender–based sexual violence increases health risks:** Sexual violence and prostitution make adolescent girls acutely vulnerable to sexually transmitted diseases. In Cambodia, it was estimated that 60 to 70 per cent of child victims of prostitution were HIV positive. For both adolescent girls and boys, more assistance is required in information and counselling, family planning, diagnosis and treatment of sexually transmitted diseases, and protection from and treatment of HIV/AIDS.

**Young people living with disabilities desperately need attention:** Article 23 of the CRC obliges States to ensure effective access of disabled children to education, health and rehabilitative services. Some 4 million children worldwide live with disabilities caused by armed conflict and political violence (Machel, 1996:43). One survey of mine victims in military hospitals in Cambodia found that 43 per cent had been recruited as soldiers between the ages of 10 and 16.

Adolescent girls

In refugee or displaced camps, where resource distribution is often controlled by men, young single women and female–headed households are typically disadvantaged in terms of accessing resources. Consequently, female–headed households tend to be more poorly nourished than other households. The health of displaced adolescent girls is thus commonly poorer than that of boys. The health and nutritional status of girls, therefore, need to be kept under surveillance.

Psychosocial care

Traumatic events coupled with the loss of guidance and conventional role models, mean that emotionally maturing youth are vulnerable to psychological harm. Manifestations of aggressive and delinquent behaviour are more frequent among adolescents than among younger children. As young people are found to be more reluctant in seeking health care, and because their adult–type behaviour may cause them to be neglected by others, special attention is also needed to ensure that adolescents and youth receive adequate and appropriate psychosocial care.
Rehabilitation strategies

Addressing biases and root causes

Rehabilitation and recovery processes need to assimilate past lessons and understanding. The Machel Report stresses the continued inadequacies of the international system in protecting the rights of child combatants and securing their well-being following demobilization. The greatest tragedy for demobilized adolescents would then be for the gun to be replaced with empty promises. Violence would then continue there unless peaceful ways are found to engage socially excluded young people. Many conflicts are fought in the rural areas. Often, however, there is an urban bias in rehabilitation programmes and in the distribution of educational, training and employment facilities.

Institutional rehabilitation

The CRC (article 39) recognizes the child’s right to recovery in an “environment which fosters the health, self−respect and dignity of the child,” and emphasizes the family’s and the community’s role in providing this. The revival of trust among young people in family institutions and within the state will be critical to any rehabilitation process. The rebuilding of civic and civil institutions is central to post−conflict rehabilitation. State institutions, kinship groups, community associations, religious organizations, and cultural and sporting clubs, and ghetto institutions can all have a role in rehabilitating adolescents and youth. Meeting adolescents rights to recreation may provide an important opportunity for making contact with them, and may be a key entry point for fulfilling and protecting a wider range of rights, in both the response and rehabilitation phases.

Supporting the socially excluded

Hardened combatants and adolescents who have left the family or whose families have been killed may not elect to return home. They may prefer to start a life elsewhere and to maintain their independent status. Reintegration into the family and community may be complicated where young people are accused of war crimes against the community. Child soldiers are often perceived as particularly threatening and may be hated by their community for their crimes. Initiated into another way of life, pre−teenage warriors may be regarded as ‘dubiously human’, a ‘threat to the very idea of society’ and thus people to be hunted down and killed. This subversion of some of society’s most powerful cultural norms goes some way to explain the terrorist activities that young soldiers engage in.

Adolescent and youth−headed households

In September 1995, UNICEF and the Rwandan Ministry of Labour identified 1,939 children living in child−headed households. Adolescent and youth−headed households face particular problems during recovery and rehabilitation:

• Adolescents and youth may not have the authority and status that age confers and therefore lack access to resources or participation in decision−making.

• Many such households are headed by adolescent girls who are vulnerable to labour and sexual exploitation.

• Young married couples require access to land, income and shelter; however, tradition or law may dictate that youth and women−headed households lack inheritance rights. There may be an acute need for legal protection of their land and property rights.

National frameworks that discriminate against women, girls and adolescent and youth−headed households should be challenged.

Education and training

Ensuring adequate access to education for all must be critical to any post−war recovery programme; education should be a right, not a privilege. Where conflicts have been fought in rural areas, investment in rural training programmes or institutes might be more appropriate than investment in formal education, with its bias towards urban needs. Youth combatants who may have fallen behind in their education, compared to younger children, may benefit from ‘progress’ schools, where they are able to catch up.
Young girls who have suffered sexual abuse may also be ostracized by their families, in addition to the many other ways in which this undermines their physical and psycho-social health and well-being.

Employment and income generation

For many youth, especially those with dependents, the first priority will be to secure a source of income. Post-war, the economic opportunity structure of a country will be severely weakened, and competition for employment severe. Special and careful consideration should be given to adolescent and youth employment and vocational training schemes:

- Apprenticeships are a common practice in many countries and should be assessed as alternatives to institution-based vocational training schemes. However, such schemes can be open to abuse.
- In post-conflict rural areas with high displacement, investment in rebuilding the rural economy will be vital to encourage people to return and to prevent out-migration.
- Long-term displacement can affect skills and knowledge such as herding or cultivation, which children would normally learn by accompanying adults. Training may be needed in these basic skills.
- For some combatants, the military will need to be recognized as a vocation.

Psychosocial needs

The traumatic impact of war on the psychological well-being of children is widely recognized as a critical issue in post-conflict recovery programmes. The following must be considered in addressing the unique rehabilitation needs of youths and adolescents:

- Depression, delinquency, aggressiveness and restlessness are more common in adolescents and youths than in younger children.
- Long-term substance abuse is a common problem among adolescent combatants.
- Boy and girl combatants may be ostracized for actions against their families, communities and traditions.
- Communities may need to be more aware of the losses felt by adolescents and youth through their involvement in combat.
- Community-wide healing, such as providing young people with meaningful tasks in the rebuilding of their community, may be preferable to individual therapy.

Caregivers

Consideration needs to be given to the training needs of caregivers for working with adolescents. Caregivers include parents, teachers, health workers, social workers, youth leaders, religious and traditional leaders, relief personnel, and adolescents who are caregivers themselves.

Gender disparities

Armed conflict can affect the demography of an area. The genocidal war in Rwanda, for example, changed the demographic composition of the country, so that women and girls are now 60 to 70 per cent of the population. This places additional pressures on adolescent girls. New roles placed on young women, such as in income-earning, affect the well-being and development of the individual and the family.

Broader rehabilitation needs

Dealing with structural issues such as land reform, or the rebuilding and strengthening of state institutions, can be part of the strategy to support young people. They may locate the political causes of the conflict in their country in the weakness of the State. The collapse of the State on which adolescents depend for education and employment can be a contributory factor in the war. Support for the creation of strong and accountable structures of government, and investment in educational and employment programmes, may be important in
engendering confidence among alienated young people. The policies of major donors, however, have tended to stress disinvestment in the State.

Adolescent and Youth Participation in Recovery

| Psychosocial concern for the healing of individuals should not replace concern for broader social and economic recovery, which will help to create a broader environment that will have particular impact on the future psychosocial well-being of young people. |

Recognizing maturity and capacity

With maturity comes an increase in control over one’s life and a capacity for decision-making due to the following.

- In many ways, young people have the greatest stake in shaping a better future.
- Young peoples’ social exclusion can be a contributory factor in armed conflicts, yet they are rarely mentioned in reconstruction and recovery plans.
- Forcibly recruited as combatants, adolescents and other young people are often summarily demobilized without regard to their special needs.

A significant consideration in programmes for adolescents and youth is to recognize not just their potential but their right to participate in decisions that will affect them.

Building on resilience and resourcefulness

Understanding how young people survive, manage and reshape cultures of violence should be a starting point for adolescent-focused programming, which should seek to build upon their resilience and resourcefulness.

- During armed conflicts and other emergencies, adolescents and youth show great resilience and resourcefulness in maintaining the cohesion and survival of their families and communities.
- Adolescents are often forced to grow up fast, to take on greater responsibilities and perform adult tasks.
- As heads of households, adolescent girls and boys become responsible for the protection and maintenance of minors.

Articles 12 and 13 of the Convention advance the right of children to express their views freely in matters affecting them, and hold that a child’s views be given due weight in accordance with his/her age and maturity.

Encouraging youth involvement in meeting needs

Young people must help to identify and contribute to their own needs. To ensure their needs are met, adolescents and youth should be involved in the design and implementation of community-based relief, recovery and reconstruction programmes such as the following.

Age- and needs-appropriate activities: There will be a need to distinguish appropriate activities for different age groups and different genders. Activities for 10-year-olds are likely to differ from those for 17-year-olds. And the needs of orphans and amputees differ from those of other young people.

Health needs: Health programmes that involve adolescents in their design have been found to be more relevant and to make important contributions to the health and development of young people.

Caring for children: Adolescents’ involvement in developing and implementing programmes for younger children can give them a sense of meaning and purpose. Child–to–child care has proven to be beneficial for the management of disease and for psychological disturbances.

Administrative support: Employment opportunities are likely to be limited in war-torn economies, even for well-educated young people and adults. Educated youth can work effectively as secretaries with traditional
institutions of elders in support of local peace processes.

**Cultural activities and practices:** These are often an unappreciated resource that can be drawn on in developing culturally appropriate recovery programmes for adolescents and youth.

**Physical work:** Post-war, the life of families and communities are reconstructed and healed through physical work as well as social care. Adolescents and youth can play an active role in this, for example, through the rehabilitation and construction of schools.

Empowering Youths and Adolescents

Ways need to be found to empower young people and to instill within them a sense of security, strength and capacity to affect change without recourse to violence. Involving ex-combatants in community service and reconstruction can provide an opportunity for those youth concerned with issues of justice to address, through nonviolent means, some of their ideological aspirations that may have led them to take up arms. Care should be taken, however, against exploitation.

It will be particularly important to ensure that there is a focus on life skills for adolescents, so that in addition to the information that they need, attempts are also made to strengthen their psychosocial competencies – such as their abilities to communicate, to negotiate and deal with conflict, and to resist peer and adult pressure. There are growing examples of programmes that help develop these skills, and a life skills element will be important to a range of programmes, from those dealing with HIV/AIDS to peace education.

Young people have a variety of paths by which to become involved in the rehabilitation and reconstruction of their society by working with:

- NGOs
- humanitarian and community development groups
- religious organisations
- student movements
- mainstream politics
- the media
- the arts
- sports and other activities

Voluntary organizations have provided a platform for young people’s expression in ways that formal political processes do not allow.

Research reveals that adolescents and youth are very capable of articulating their needs, fears and their future ‘vision for their country’. Their own interests can provide a lead in developing effective programmes. In conclusion, ways of involving youth in the design and implementation of programmes are many and include:

- raising awareness among adolescents and youth of their rights under the CRC, and other humanitarian and human rights laws;
- promoting the participation of youth in day-to-day planning and construction activities, such as of shelter and schools, including their involvement in decisions about the management of camps;
- promoting child-to-child teaching in subjects such as mine awareness and HIV/AIDS;
- supporting peer education as a means of including young people in planning health, education and sports initiatives, and in influencing the behaviour of adolescents and youth.

Collaboration and Partnerships

| Youths and the Media |
The globalization of communications means that young people are not isolated from the wider aspirations of youth and adolescents or the global youth culture. While media violence has been an ‘inspiration’ for youth politics, the opportunity exists to utilize this interest in the media for positive ends, by using it to promote youth issues.

Given the general lack of focus on adolescents and youth by most relief agencies, inter−agency collaboration is critical to ensure that the unique needs of young people are addressed. Other UN agencies and NGOs, within their mandates, should be encouraged to take responsibility for the protection and assistance of young people. An appropriate division of labour should include:

- **WHO, UNHCR and UNFPA** with special responsibilities for the prevention and management of health issues confronting adolescents and youth, including those related to violence against women and girls during armed conflict.

- **WFP and UNESCO**, with support for education, recovery and integration of adolescent combatants.

- **FAO**, with appropriate support for adolescent−headed rural families, geared towards food security.

- **UNESCO, UNDP, UNICEF, UNHCR, and ILO** to jointly develop programmes for child soldiers, adolescents and combatants, in the areas of information, sports, recreation, mine awareness and peace education.

- **ILO** to support vocational rehabilitation and livelihood schemes for the rehabilitation and reintegration of adolescents and child combatants.

- **The World Bank**, with a concern for enhancing human/social capital.

- **NGOs** involved in advocacy, research, human rights monitoring, training, and humanitarian assistance/fulfilling and protecting adolescents’ rights in conflict situations and complex emergencies should be lobbied to incorporate young people in their programmes.

**Further Guidance**


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While programmes for adolescents and youth can, for the most part, be incorporated into on-going child assistance and protection programmes, additional human resources specializing in adolescent and youth issues may be needed.

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Chapter 10 – Annex 1: Safe Places for Young People

One of the key components of UNICEF’s programming approach to adolescents and other young people is the creation of safe and supportive environments in which they can live and learn. This includes both the immediate environment of parents, peers and service providers, and also the wider environment created by policies, social values and norms of behaviour.

In addition to programmes directed to families and schools, there are increasing examples of countries focusing on the creation of safe places/spaces for adolescents and youth in their communities, many of which provide information and services to young people and at the same time galvanise and harness their energy, creativity and potential.

These models can be replicated and expanded in crisis and post-conflict environments. Services have been provided in a variety of ways through innovative ideas coordinated and implemented by young people themselves and by a range of service providers including teachers and the staff of NGOs. Strong, successful and sustainable programmes require the participation and commitment of young people themselves. In crisis
and emergency settings, establishing the trust, respect and participation of adolescents and youth is the beginning of reconstruction efforts, and has a ripple effect throughout the wider community.

Key components of Safe Places

UNICEF has identified several key components in the establishment of Safe Places for Young People:

Core goals: These can include enhancing practical knowledge, personal strength and coping and decision-making skills. Such goals can stand alone, be incorporated into strategies to achieve specific objectives or complement other developmental goals.

Location: Safe Places for Young People can be established in existing facilities and can be open according to demand and available resources. Outreach is necessary for promotion and information.

Young people’s participation: This is essential in creating and running Safe Places in order to help create adolescent/youth–friendly environments. Professionals supporting Safe Places should be skilled in supporting the participation and leadership of young people.

Core activities: These include provision of information, non-judgmental listening, discussion and social and recreational activities. Discussions may lead to the identification of activities that young people want to undertake in order to meet other needs, such as formal education, vocational income generation and community service. Safe Places can add such activities to core activities, or work in collaboration with other organizations and service providers.

Training: Safe Places are strengthened through training young people for various roles that help inform and support their peers; involving professionals as required to work collaboratively with young people; and training both peer and professional leaders in project planning and management.

Strategies for monitoring and evaluation: These should generate quantitative information about how Safe Places are used and how specific objectives are met, as well as qualitative information (including personal stories, programme development reports and group statements). Involving youth in monitoring and evaluation can enhance their sense of ownership as well as their ability to contribute to maintaining and improving Safe Places for Young People.

The core activities identified above:

- provision of useful information
- non-judgmental listening and discussion
- referral to other services

all figure more or less prominently in existing Safe Places for Young People. They occur:

- as central activities of the Centres d’Ecoutes in Mali;
- as informal activities within schooling at the Samaritan Orphanage in Malawi;
- among the activities in multipurpose youth centres in Grenada and Mexico;
- during recreational, cultural and community service activities of the Youth Development Association in Bhutan.

Almost all Safe Places include recreational and social activities, which attract youth, create an informal atmosphere and help build friendships. As their name suggests, Friendship Clubs in Former Yugoslavia offer primarily social activities to help refugee youth reconnect with society. Some of the main activities undertaken apart from the core activities include formal education, vocational training, income–generating projects and community service.

Wider Application

In crisis and post–crisis affected societies, Safe Places can also be used to address specific issues arising from the demobilization and reconstruction process. Youth can be mobilized for community mapping and
reconstruction projects. They can help in literacy programmes and preparation of materials, drama and other cultural activities promoting health education, mine risk awareness, and other public issues. Mentoring and buddy systems can be developed to help younger or orphaned children and former youth combatants. In societies such as Somalia and Sudan, where much cultural and historical material has been lost or destroyed through war, youth centres can be the focus for the re-documentation and retelling of legends and traditions as a contribution to reshaping the future. Young people’s own interests and link to global youth culture can be used in imaginative ways to initiate conflict resolution measures and to foster a culture of peace and reconciliation.

Adapted from a paper by Angela Raven–Robert, Project Officer in the Office of Emergency Programmes, UNICEF, New York; and Dr. Bruce Dick, Senior Advisor for Youth Health in the Health Section, UNICEF, New York.

See also UNICEF, Brian Hill, Safe Places for Youth: Programming, strategy and examples as identified through interviews with participants of the World Youth Forum of the UN system, 1996.

Chapter 11: Sexual Violence

Rationale

Rape and other forms of gender–based violence, including forced prostitution, sexual humiliation and mutilation, sex trafficking and domestic violence pose a continual threat to women and girls during emergency situations. Rape can occur due to the disruption of social boundaries including licence granted to soldiers and militia. And it is often used as a weapon to humiliate and weaken the morale of the enemy or to terrorize populations or force civilians to flee.

Rape constitutes a violation of international humanitarian law but has often been downplayed as an unfortunate, yet inevitable side effect of war. When gender–based violence occurs on a massive scale or as a matter of policy, it is a crime against humanity.

Women of all ages may be victims of sexual violence, although young adolescent girls are particularly at risk due to their age and low status in society. Ethnicity, class, religion or nationality may also determine which women or girls are subjected to violence. Women and girls are at risk in all emergency locations − in the home, during flight or in camps.

Most child victims of sexual abuse are girls, but boys, though underreported, are also affected. Abused boys often then become perpetrators of sexual violence against girls. Children who witness the rape of a family member and those who are ostracized because their mother has been assaulted are also victims.

Basic Principles

<table>
<thead>
<tr>
<th>General Aims</th>
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<tbody>
<tr>
<td>• prevent/reduce the risk of sexual violence</td>
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<tr>
<td>• protect survivors from further suffering and promote their physical and psychological recovery</td>
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</table>

• Violation of the human rights of women and girls is life–threatening; its prevention is no less important than other life–saving activities during an emergency.

• Relief services and settlements or refugee camps must give priority to the protection of women and children, particularly unaccompanied children from sexual violence.

• The community, particularly its women, must be involved in the information and education activities for prevention measures to be effective.
Refugees or displaced persons rely on all their psychological defences to survive. Therefore, an individual’s desire not to disclose a sexual attack must be respected. This means ensuring that making medical and psychosocial assistance is freely available to all persons, not just the identified victims.

Physical and psychological recovery is dependent on services being provided in a relatively safe, stable environment. Such services may not be available in situations of ongoing civil strife, and therefore special efforts need to be made to enhance women’s access to these services.

Given the cultural sensitivities associated with sexual violence, it is essential to ensure privacy to survivors receiving medical or psychological care. There must be strict confidentiality of documentation during communication with survivors, their families, witnesses and alleged perpetrators.

All caregiving personnel should be of the same sex as the survivor of sexual violence.

Field–Level Strategies and Actions

Supporting strategies:

- Mobilize the community to develop a preventative plan using existing resources and mechanisms.
- Promote guidelines to limit further trauma to survivors of sexual violence.
- Sensitize medical and other service providers, including the law enforcement and security patrols about sexual violence.
- Ensure adequate medical attention for survivors of sexual violence, respecting their right to privacy.
- Ensure timely and appropriate psychosocial support for survivors and their families.

Field–level strategies for dealing with sexual violence should ensure protection, reduce the risk of such violence, protect survivors, and promote physical and psychological recovery.

Preventive Measures

Preventive measures to reduce sexual violence should include the following.

Design camps to increase the security of women: Women and adolescents are at greatest risk when they must travel away from their homes and communities for food, water, fuel wood or to use communal latrines. Improved lighting, widened paths to water and fuel/wood sources; security patrols of women, wherever possible, and group accommodations for unaccompanied females and children are some of the interventions to promote physical safety.

Delegate women to distribute relief items to women: Too often women are coerced to engage in sexual relations in exchange for essential relief supplies.

Involving existing community organizations: Hold separate meetings for women and men to receive everyone’s input on the need and possible mechanisms for prevention and protection. Where there are no women’s groups, promote their formation. Ask organizations to support vulnerable groups through such initiatives as women’s income–generating projects and emergency credit schemes, volunteer security escorts and communal food preparation.

Include beneficiary women in decision–making processes: This is especially important in areas of health, sanitation, education, reproductive health, and food and water distribution. Ensure they are protected from repercussions and backlash as a result of their participation.
Recognize the influence of teachers and religious and traditional leaders on the community: Enlist their cooperation in changing attitudes and behaviours. They can be involved in educating their followers on the causes and consequences of sexual violence. Ask them to encourage the reporting of sexual attacks, domestic abuse and involuntary prostitution.

Convene specific discussions with medical and other service providers on the topic to discuss the above strategies.

Individuals at risk, such as unaccompanied women and children and female heads of household, should be identified and appropriate strategies developed to ensure their protection.

Provide women in communities with materials to protect themselves: e.g. barbed wire, whistles, and self-defence training.

Carefully screen foster families for unaccompanied children: This is critical to avoid the possibility of sexual abuse of children by their foster parents and their relatives. Provide adequate monitoring after placement to ensure the continued well-being of children (see Chapter 4, “Children Separated From Families”).

Support public information campaigns: Campaigns should be designed to sensitize women and girls to the risks, correct false rumours, misconceptions and misinformation about the extent and nature of sexual violence. Make use of the media as a training vehicle for women and to alert the public to widespread sexual violence.

Make the perpetrators and those in charge of protecting women and children’s rights accountable: This must be done in all relief programmes and the implementation of prevention measures must be monitored. All cases of slackness must be noted for immediate corrective action.

Measures to Support Survivors

The extreme sensitivity surrounding sexual violence demands careful handling. In supporting survivors of sexual violence, it is important to do the following.

- Educate community members as to where they can go for help in the event of a sexual attack.
- Ensure that confidentiality will be respected.
- Establish protocols and guidelines that will limit further trauma to survivors of sexual violence.
- Identify, train and retrain socially and culturally appropriate support personnel.
- Involve traditional birth attendants (TBAs) and health workers in the monitoring and reporting of cases of sexual violence.

Medical Response

The initial medical examination and follow-up action should be conducted preferably by a health worker of the same sex as the survivor. Immediate treatment may include diagnosis and drug therapy for sexually transmitted diseases based on observed syndromes, analgesia, post-coital contraception, antibiotics, tetanus toxoid/immunoglobulin injection, pregnancy test. Testing for HIV should be done.

In situations of rape during armed conflict or where the population is known to have a high rate of STD/HIV infection, the risk of STD transmission should be assumed. Prophylactic therapy, i.e. use of appropriate antibiotics without making a clinical diagnosis, should be given to cover gonorrhoea, chlamydia and syphilis, as these infections left untreated have long-term devastating consequences (see the annex on Prevention and Treatment of STDs/HIV for a full description of the medical care of patients suspected of being infected with any one of these diseases).
Psychosocial Response

Timely counselling by mental health professionals is essential to prevent long–lasting psychological effects. Immediate intervention can be effective in minimizing the severity of psychological trauma. However, the survivor must be willing to forego counselling, never pressured into it (see also Chapter 14, “Protecting Psychosocial Development”).

Support by the survivor’s family and friends is the most important factor in overcoming trauma. Sexual violence can have severe traumatic effects on family members and close friends who witnessed the crime and were unable to intervene or who feel guilty for not having been present to prevent it. If the survivor concurs, individual and family counselling should be given, with male counsellors approaching male family members.

Informal and formal women’s groups can be very useful for therapeutic assistance as well as preventative measures. Encourage the establishment of groups around useful activities, such as income–generating projects, which help survivors to regain control over their daily lives. Preference should be given to activities that address the survivor’s psychosocial needs generally rather than focusing specifically on sexual violence.

Further Guidance


UNHCR, Reproductive Health in Refugee Situations: An Inter–agency Field Manual, 1999

Panels

Panel 1 – Principles Relevant to Sexual Violence

<table>
<thead>
<tr>
<th>PRINCIPLES RELEVANT TO SEXUAL VIOLENCE</th>
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<tbody>
<tr>
<td>Key principles relevant to sexual violence are based on the following:</td>
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<tr>
<td>• Universal Declaration of Human Rights</td>
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<tr>
<td>• International Covenant on Civil and Political Rights</td>
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<tr>
<td>• Convention on the Rights of the Child</td>
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<tr>
<td>• UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment</td>
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<tr>
<td>• Convention on the Elimination of All Forms of Discrimination against Women (see Chapter 8, “Gender Issues”)</td>
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<tr>
<td>• International Declaration of the Elimination of Violence Against Women</td>
</tr>
<tr>
<td>• Rome Statute of the International Criminal Court (not entered into force as of 2000)</td>
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</tbody>
</table>

Highlights include:

• no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment;
• sexual violence against women constitutes a violation of the rights and fundamental freedoms of women;
• sexual violence is prohibited;
• systematic mass rape is a 'crime against humanity';
• states should take all appropriate measures to protect children against sexual violence.

Panel 2 – Consequences of Sexual Violence

<table>
<thead>
<tr>
<th>CONSEQUENCES OF SEXUAL VIOLENCE</th>
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<tr>
<td><strong>Psychological and social consequences:</strong></td>
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<tr>
<td>Each survivor of sexual violence experiences and copes with the traumatic incident differently. The survivor most commonly expresses fear, helplessness and humiliation. He/she is likely to experience a loss of trust and a lost sense of safety and security. The female survivor often feels unclean and unworthy, resulting from the cultural values of virginity and female chastity. Males are similarly defined in many cultures in terms of their manhood and virility and, therefore, the experience of sexual violence can have a devastating psychological impact on a boy.</td>
</tr>
<tr>
<td>For a child, sexual abuse can have particularly harmful long–term psychological and psychosocial consequences. Therefore, the nature of a sexual attack on a child is a matter of significance: Was the violence perpetrated by a stranger, neighbour or family member, and is the abuse likely to recur or was it an isolated event? A child may also suffer as a result of sexual violence experienced by the child’s mother. Experiencing one traumatic event can compromise a mother’s ability to care for her children.</td>
</tr>
<tr>
<td>A survivor’s trauma may manifest into aggressiveness, anger and hatred. While expressions of simple anger alleviate feelings of self–blame, a survivor also can become destructive and vengeful. Reactions range from minor depressions, grief, anxiety, phobia, somatic problems to serious and chronic mental conditions. Extreme reactions include suicide, or in the case of pregnancy as a result of rape, self–abortion, child abandonment or infanticide. A survivor can respond to sexual violence by ‘psychic numbing’, a defensive reaction muting the person’s emotions. He/she may feel numb, show little feeling, speak slowly and inaudibly, and appear very calm.</td>
</tr>
<tr>
<td>The social consequences to a survivor of sexual violence range from rejection by one’s spouse and immediate family members to stigmatization or ostracism by one’s community, further sexual exploitation or severe punishment.</td>
</tr>
<tr>
<td><strong>Physical consequences:</strong></td>
</tr>
<tr>
<td>The physical consequences of sexual violence may include human immunodeficiency virus (HIV) infection and other sexually transmitted diseases, mutilated genitalia, pregnancy, miscarriage, abortion, menstrual disorders, severe abdominal pain or self–mutilation. The risk of contracting HIV from an infected rapist is increased by injuries caused to the woman’s genital tract during forced sexual intercourse. Girls in puberty are particularly vulnerable to the effects of STDs because the linings of their genital tracts have yet to take on adult character. Women and girls who have undergone extreme forms of female genital mutilation may suffer extensive injuries if their genitalia are reopened by a sharp instrument or by the force of penetration (see also Annex 9, Chapter 1 on the Prevention and Treatment of STDs/HIV).</td>
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</table>

Chapter 12 – Child Combatants

**Rationale**

One of the most alarming trends in armed conflicts is the participation of children as soldiers. This is in direct contradiction of the Convention on the Rights of the Child (CRC), the Optional Protocol to the CRC on the
involvement of children in armed conflict, the Geneva Protocols and other international human rights laws. Over the last 30 years, government and rebel armies around the world have recruited tens of thousands of children. Most are adolescents, though many child soldiers are 10 years of age or younger. While the majority are boys, girls are also recruited. Many child soldiers die in battle, and those who survive face major physical, psychological and social challenges.

Children are recruited in a number of different ways. Some are conscripted, others are press-ganged or kidnapped, and still others are forced to join to defend their families. Some recruits are arbitrarily seized from the streets or even from schools or orphanages. Children also ‘voluntarily’ enlist as a means of ensuring protection, obtaining regular food or clothing, or gaining power and status. Others are lured by ideology and societal indoctrination. Many enlist to fight for social causes, religious expression, self-determination or national liberation.

Child soldiers often play supporting roles associated with great risk and hardship, such as porters, messengers and spies. They are also increasingly found in active combat roles, where their inexperience and lack of training leave them particularly vulnerable and unaware of the perils they face. Child fighters are sometimes even considered desirable ‘because they are more obedient, do not question orders and are easier to manipulate than adult soldiers’. Child soldiers are often deliberately exposed to horrific scenes or forced to commit atrocities against their own families or communities. The treatment of girl soldiers is especially bad, with repeated sexual abuse added to the other traumas.

Guiding Principles

<table>
<thead>
<tr>
<th>General Aims</th>
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<tr>
<td>To eliminate conscription of children, forced or otherwise, and ensure the demobilization, recovery and reintegration of existing child soldiers.</td>
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</table>

Supporting strategies include:

- raise awareness of the Convention on the Rights of the Child, its Optional Protocol, the Geneva Conventions and other international human rights instruments, as they apply to child soldiers;
- advocate against child recruitment and for the immediate demobilization of child soldiers; and
- promote the physical and psychological recovery of child soldiers and their successful reintegration into society.

The Geneva Conventions and the Convention on the Rights of the Child provide the guiding principles for UNICEF’s work with child soldiers. Excerpts of the relevant Geneva Conventions and CRC provisions are provided below.

**Article 4(c), Protocol II to the Geneva Conventions**: ... children who have not attained the age of fifteen years shall neither be recruited in the armed forces or groups nor allowed to take part in hostilities.

**Articles 77(2) and 77(3), Protocol I to the Geneva Conventions**: The Parties to the conflict shall take all feasible measures in order that children who have not attained the age of fifteen years do not take part in hostilities and, in particular, they refrain from recruiting them into their armed forces. If, in exceptional cases, ... children who have not attained the age of fifteen years take a direct part in hostilities and fall into the power of an adverse Party, they shall continue to benefit from the special protection..., whether or not they are prisoners of war.

**Article 38, CRC**: (1) States Parties undertake to respect and to ensure respect for the rules of international law applicable to them in armed conflicts which are relevant to the child. (2) States Parties shall take all feasible measures to ensure that persons who have not attained the age of fifteen years do not take a direct part in hostilities. (3) States Parties shall refrain from recruiting any person who has not attained the age of fifteen years into their armed forces. In recruiting among those persons who have attained the age of fifteen years but who have not yet attained the age of eighteen years, States Parties shall endeavor to give priority to those who are oldest. (4) In accordance with their obligations under international humanitarian law to protect
the civilian population in armed conflicts, States Parties shall take all feasible measures to ensure protection and care of children who are affected by an armed conflict.

**Article 39, CRC:** States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation or abuse; torture or any form of cruel, inhuman, or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self–respect and dignity of the child.

### Field–Level Strategies and Actions

#### Optional Protocol to the CRC

To increase the protection of children involved in armed conflict, some States wished to see the minimum age for recruitment and participation set at 18. This was adopted by the General Assembly on 25 May 2000.

UNICEF supports the Optional Protocol on the involvement of children in armed conflict, and advocates for the complete prohibition of children below 18 years old to participate in armed conflicts. UNICEF should be active in supporting all aspects of advocacy and actions for children’s demobilization, recovery and reintegration.

#### Advocacy

Advocacy against child recruitment and for immediate demobilization of child soldiers is perhaps the most important strategic intervention in addressing the problem of child soldiers. Two main approaches are taken in advocacy efforts: quiet diplomacy and constructive engagement with authorities, through which specific concerns are raised and addressed; and, when necessary, bringing public pressure to bear on authorities through publicizing and openly condemning rights violations.

#### Raising General Awareness of Child Rights

Intensive awareness–raising efforts are an essential first step in addressing child soldiers. Experience from El Salvador, Guatemala, Paraguay, Peru and elsewhere has shown that the recruitment of children can be minimized:

- if local communities are aware of national and international laws governing the age of recruitment;
- if they are sufficiently organized and determined.

(Grãça Machel Report)

Advocacy efforts should emphasize the following:

- promoting unconditional demobilization of under–aged soldiers and an immediate end to the practice of under–age recruitment;
- obtaining signed official commitments from the government, and from de facto rebel authorities not bound by international instruments, to renounce and discontinue the practice of under–age recruitment;
- promoting government to establish effective and legal remedies and institutions to tackle abuses;
- promoting government commitment to the ratification of the Optional Protocol to the Convention on the Rights of the Child raising the minimum age of recruitment and participation in the armed forces to 18 years;
- developing an appropriate legal or institutional framework for children accused of war crimes, and supporting authorities in housing accused young combatants in jails separate from adults, where basic rehabilitative services will be provided (see Chapter 13, Children in
Detention;

- ensuring that all peace agreements include measures to demobilize and reintegrate child soldiers into society, with provision made for the special needs of demobilized girl soldiers (see Panel 1).

Promoting Psychosocial Reintegration and Recovery

**Reintegration and recovery includes:**

- family reunification
- mobilizing and enabling the child’s existing care system
- schooling and vocational training
- psychological healing
- social reintegration
- medical screening and care

**Family reunification**

Reunifying former combatants with their families, or finding alternative family– or community–based care arrangements, is the first step to their recovery and reintegration. While some children can stay with relatives or know the location of family and can immediately be returned upon release, many more require initial care and support as unaccompanied minors.

A significant portion of child soldiers were unaccompanied before being conscripted into service, complicating reunification efforts. Documentation, tracing and reunification activities should be combined with ongoing community– and family–based arrangements for the care and protection of children. Details of this approach are presented in detail in Chapter 4, Children Separated from Families.

**Mobilizing and enabling the child’s care system**

Mobilizing the family, as well as teachers, health workers, social workers, youth leaders, religious leaders, traditional healers, etc., within the child’s community – and providing them with appropriate knowledge and skills – is vital in promoting the child’s psychological healing and social reintegration.

**Recognizing difficulties in reintegration**

The process of healing and reintegration is often difficult for both the children and their caregivers. Children and adolescents may be reluctant to return home due to the fear of rejection, a lack of security and support outside of the military, or a basic loss of identity. Families and communities may be fearful of the child or fearful of retribution or revenge for the child’s past actions.

It is therefore important to inform caregivers of the child’s experiences, the child’s view of what happened, and the difficulties the child will have adjusting to life outside the military. The perception of the child soldier as a victim and not a perpetrator is often difficult but must be understood and accepted. Forgiveness by adults is required before reintegration can occur.

**Schooling and vocational training**

Re–entry into school is critical to the rehabilitation of child soldiers. In addition to imparting key life skills and knowledge, schooling helps the child re–establish a daily routine, develop an identity separate from that of a soldier, form healthy peer relationships, and build self–esteem. Former child soldiers are likely to be well behind the educational level that corresponds to their age and therefore require special remedial measures.

Teachers may be reluctant to accept former combatants for fear of their disruptive influence and may be ill–equipped to meet their needs without special support and training. Older children will require training in life skills and vocational opportunity to help them survive, facilitate their acceptance at home and provide them with a sense of meaning and identity. It is generally preferable to integrate former combatants with other trainees in vocational programmes, to encourage assimilation and avoid further segregation.
Psychosocial healing

The recommendations of Chapter 14 for promoting psychosocial well-being and recovery are directly applicable to former child soldiers. The issues discussed above, i.e. reintegrating the child into a stable and nurturing family environment, activating the child's existing support system and re-establishing age-appropriate daily routines, including schooling, are important factors in psychological recovery.

However, the abuse and horrific violence that child soldiers are often exposed to result in some being severely traumatized and in need of specialized care and counselling. This should take place in a stable, supportive environment by caregivers who have solid and continuing relationships with the child and should not further segregate the child. Existing cultural traditions for dealing with distress and trauma should be recognized and built upon, and traditional healers involved where appropriate.

Medical screening and care

Children suffer physically as well as psychologically as combatants and require medical screening and treatment as an immediate priority following demobilization. Child soldiers often suffer extreme physical deprivation and are often victims of both physical and sexual abuse at the hands of older soldiers.

Poor health observed at demobilization may include the long-term influence of substance abuse, at times administered forcibly, which in some instances results in brain damage and consequent impairment of cognitive functioning. Children may also have contracted AIDS or other sexually transmitted diseases. Child combatants suffering physical disabilities are best served by community-based rehabilitation, to help prevent their further marginalization and rejection.

Further Guidance


McCallin, Margaret, ‘The Reintegration of Young Ex–Combatants into Civilian Life’ paper prepared for the Vocational Training Systems Management Branch of the International Labour Office, Geneva (The report includes six case studies from five African countries)

Panels

Panel 1 – Disarming Child Soldiers
UNICEF is the lead agency for the demobilization of child soldiers in Liberia, a country where child soldiers have been widely used during the prolonged civil war. UNICEF actions are based on articles 38 and 39 of the Convention on the Rights of the Child and on the Optional Protocol on the involvement of children in armed conflict:

States Parties shall take all feasible measures to ensure that children under 15 years of age have no direct part in hostilities. No child below 15 shall be recruited into the armed forces. States shall also ensure the protection and care of children who are affected by armed conflict as described in international law (article 38). The age limit has been raised to 18 years of age as the minimum to participate in armed conflicts as per the Optional Protocol.

State Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any form of cruel, inhumane or degrading treatment or punishments; or armed conflict (article 39).

As part of a broader effort to mobilize Liberian civil society groups around the child soldier issue, UNICEF organized a seminar in which over 15 Liberian civil society groups and NGOs gathered to define the role of civil society in the demobilization and rehabilitation of child soldiers and in helping other war-affected children. Together with SCF-UK and Don Bosco Homes, UNICEF has initiated a programme supporting the reintegration and recovery of child soldiers who voluntarily decide to put down arms and seek assistance. The programme provides the former soldiers with interim housing/care, psychosocial counselling, tracing and family reunification.

Chapter 13: Children in Detention

Rationale

Children in detention often suffer egregious violations of their basic rights. Frequently the conditions under which children must survive are deplorable and inhumane – no heat, inadequate food, insufficient beds, lice-ridden blankets, poor sanitation facilities and no exercise. Some are kept in solitary confinement for long periods. Physical abuse is common; injuries include broken bones, broken hands, damaged eardrums, bruises, and, most substantially, deep emotional trauma, often resulting from torture and interrogation.

In most cases, even the most fundamental principles of due process are violated. Arrest, detention and sentencing are often arbitrary – the results of extra judicial proceedings by police and military systems in which no civil protections exist. Detained children are often below the age of criminal responsibility and kept with adult prisoners from whom they may suffer abuse. Parents are commonly denied visitation rights and are often not informed of children’s whereabouts. The detention of children is frequently severely distressing and disruptive for their families.

Juvenile detention may result from the following circumstances:

- intimidation of the detainees’ parents or others of their community;
- persecution for being an ethnic minority or a refugee
- accompanying a parent to detention;
- being born to a parent while in detention;
- mistakes caused by inadequate or undue process of law;
- acts committed by or attributed to the child;
- lack of appropriate alternative care facilities for children with special needs, severely traumatized children, children with a mental disability, or child prostitutes;
• national laws that permit detaining children ‘for their own protection;’

• vagrancy;

• other reasons that may be legal according to national laws but contrary to the best interests of the child and the CRC.

Guiding Principles

General Aim

The overall aim of UNICEF action is to ensure the rights of child detainees as set out in the Convention on the Rights of the Child.

The Convention on the Rights of the Child provides the guiding principles for UNICEF’s work with child detainees. The main CRC provisions concerning child detainees are as follows:

Article 37: States Parties shall ensure that:

(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without the possibility of release shall be imposed for offences committed by persons below eighteen years of age;

(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time;

(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child’s best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;

(d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 39: States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation or abuse; torture or any form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and re-integration shall take place in an environment which fosters the health, self-respect and dignity of the child.

Supporting Strategies

• Advocating for the lesser recourse to the deprivation of liberty.

• Raising awareness of international law and humanitarian principles concerning child rights and child detainees.

• Advocating for the rights of child detainees.

• Ensuring the monitoring and reporting of conditions of child detainees.

• Building national capacity to administer juvenile justice based on international laws and humanitarian principles.

• Promoting the recovery and reintegration of children following detention.

Article 40(1): States Parties recognize the right of every child alleged as, accused of, or recognized as having
infringed the penal law to be treated in a manner consistent with the child’s sense of dignity and worth, which reinforces the child’s respect for human rights and fundamental freedoms of others and which takes into account the child’s age and the desirability of promoting the child’s reintegration and the child’s assuming a constructive role in society.

Article 40(3): States Parties shall seek to promote the establishment of laws, procedures, authorities and institutions specifically applicable to children alleged as, accused of, or recognized as having infringed the penal law, and, in particular:

(a) the establishment of a minimum age below which children shall be presumed not to have the capacity to infringe the penal law;

(b) whenever appropriate and desirable, measures for dealing with such children without resorting to judicial proceedings, providing that human rights and legal safeguards are fully respected.

Identifying Priorities

The careful assessment and documentation of conditions must be the basis for all advocacy and other efforts in support of child detainees. The first consideration must be reason for the arrest – if the motive is not of a criminal nature, immediate release of the child should be sought.

Panel 1 provides a checklist for field visits by UNICEF officers that could also be used as guidelines for advocacy with governmental and/or detention authorities.

Field-Level Strategies and Actions

The nature of UNICEF field-level action in support of detained children will depend on the local context and situation – the delicacy of the political environment, UNICEF’s level of dialogue with the authorities, the state of the judicial system, security concerns, the possibility of mobilizing local, national or international opinion, and a host of other factors.

Raising awareness of child rights

Enforcement of child rights, international humanitarian law and humanitarian principles related to detention of children, depends first on an awareness of these rights, laws and principles. Awareness-raising efforts should be a first priority, aimed at the public at large and at those figures who are most likely to be able to prevent or advocate against these violations – members of the judiciary, lawyers, the military, officials of governments and non-State parties, detention centre staff, journalists, officials of local NGOs, religious leaders and activists, traditional chiefs, women’s leaders, police, social workers, and others influential in society.

Advocacy

Advocacy is perhaps the most important strategic intervention in support of child detainees. Important concerns that should normally be addressed in advocacy efforts are as follows:

- the reason for arrest – if the motive is not of a criminal nature, or the child is below the age of criminal responsibility, immediate release of the child should be sought (except in rare cases where release might be life-threatening);
- the separation of child and adult prisoners;
- the conditions in which children are being detained in terms of space, living and sleeping areas, clothing and bedding, sanitary facilities, health care and nutrition, activities, and education;
- the treatment of children – whether they have been subjected to any forms of torture or cruel or inhuman treatment;
• the child’s ability to communicate with her/his family and other concerned parties on the outside;

• the ability of humanitarian workers to access and to make regular visits to children to monitor their condition and situation;

• the procedures followed for the arrest and detention of the child, and the status of the legal documentation of the child;

• the child’s access to legal representation, in situations where some semblance of a legal system remains functional.

What forms advocacy efforts take will depend on the local context and situation as noted above. Normally, however, advocacy efforts take place on two main fronts: (a) constructive engagement and quiet diplomacy with authorities through which specific rights and concerns are raised and addressed and (b) when necessary, bringing public pressure to bear on authorities through publicizing and openly condemning rights violations.

Constructive engagement and quiet diplomacy

A general policy of constructive engagement and quiet diplomacy, in which problems are addressed through seeking dialogue and consensus, may prove to be a more effective advocacy strategy than immediate public exposure and criticism. This approach avoids an adversarial relationship with the authorities, and enables a move to more in−depth dialogue on addressing the underlying causes of rights violations. Quiet but straightforward negotiations with the authorities directly responsible often leads to substantial progress.

In other situations, it can prove more constructive to engage in diplomacy and dialogue with higher authorities who are not directly responsible for detainees and therefore may be less sensitive about discussing them. Some improvement in the conditions of detention may be achieved by appeals directly to the personnel of the detention facility. Signed agreements, committing the relevant authorities to respect the rights of child detainees, are extremely important.

Publicizing rights concerns

Where constructive engagement and quiet diplomacy fail, it may be necessary to bring local and international pressure to bear on responsible authorities through public exposure and condemnation of abuses. However, the issue of public disclosure and criticism is complex, sensitive and fraught with moral ambiguities.

By taking such action, UNICEF may risk jeopardizing its programmes and the security of its staff. By not acting, it risks the perception of tacitly accepting flagrant violations of the rights of detainees. In all cases, public criticism should only be made when it is in the best interests of the detained children and there will be no repercussions against them or against agencies delivering services to them.

In some cases where UNICEF does not feel able to make public statements on the treatment of the child, UNICEF can consider providing information confidentially to organizations that are able to make information public, normally human rights groups or the media.

Advocacy for child protection in situations of armed conflict and other emergencies is dealt with in more detail in Chapter 7.

Monitoring and Reporting Conditions

The monitoring and reporting of the conditions of child detainees is an extremely sensitive and difficult area of work and must be handled with great diplomacy and tact. UNICEF’s actual role will depend on the problems, the needs and the capacities of other organizations working in the area. Although organizations such as Amnesty International, Human Rights Watch and others may issue periodic reports on human rights abuses in zones of conflict, UNICEF must ensure that there is systematic documentation of violations of children’s rights, including those relating to child detainees. This is preferably done by local institutions such as NGOs, religious groups or others. Where no such organization is involved, and taking into account the possible dangers to its own staff, UNICEF must ensure that, at the very least, by bearing witness it does not allow detained children to suffer or even to die forgotten.
Building national capacity

In order to help create longer-term solutions to the rights violations associated with child detention, it is important to follow-up advocacy efforts with building national capacity to administer juvenile justice based on international humanitarian rights, laws and principles (see annexes 1 and 2). In some countries, progress towards this end has been possible despite an ongoing complex emergency situation. Areas of support in this context may include:

- the revision/drafting of legislation on juvenile justice governing arrest, detention and sentencing in accordance with the CRC and other international instruments, such as the ‘Beijing Rules,’ the ‘Riyadh Guidelines,’ and the United Nations Rules for the Protection of Juveniles Deprived of their Liberty;
- the training of police forces and judges on children’s rights;
- the sensitization of army officers and troops on the rights of the child;
- the draft of guidelines for inspection of detention centers for children, and the creation of governmental inspection and monitoring teams on detention conditions.

Promoting Recovery and Reintegration Following Detention

The major recommendations of Chapter 12, for promoting recovery and reintegration of former child soldiers, are also largely applicable for former child detainees.

Family reunification

Reunifying former detainees with their families or, where this is not possible or desired, finding alternative family- or community-based care arrangements, should be the first priority in promoting their recovery and reintegration. Depending on the circumstances, some former detainees might not know the whereabouts of their families upon their release, in which case tracing efforts should be initiated and family-based interim care arrangements found for the child, as described in detail in Chapter 4, Children Separated from Families.

Mobilizing and enabling the child’s care system

Mobilizing the child’s existing care system – her/his family and the teachers, community health workers, social workers, youth leaders, religious leaders, traditional healers, etc. within the child’s community – and providing them with appropriate knowledge and skills through training and other vehicles is vital in promoting the child’s psychological healing and reintegration and in rebuilding her/his ability to trust.

Where UNICEF is involved in the direct monitoring and reporting of violations of child rights, certain problems should be kept in mind, including the lack of access, security of staff and witnesses, and confidentiality in reporting.

Schooling and vocational training

Re-entry into school is critical to recovery and rehabilitation. In addition to imparting key life skills and knowledge, schooling helps the child re-establish a daily routine, develop an identity separate from that of a prisoner, form healthy peer relationships and build self-esteem. Older children will require training in life skills and vocational opportunities to facilitate their acceptance at home and provide them with a sense of meaning and identity.

Psychosocial healing

The issues discussed above – reintegrating the child into a stable and nurturing family environment, activating and enabling the child’s existing care system and re-establishing age-appropriate daily routines, including schooling – are the most important factors to his/her psychological recovery. However, some of the children who have been subject to inhumane conditions in detention, tortured or raped may be severely traumatized and therefore require specialized attention and counselling. This special care should take place in a stable,
supportive environment by caregivers who have solid and continuing relationships with the child; it should not
further segregate the child. Existing cultural traditions and practices for dealing with distress and trauma
should be recognized and built upon.

Medical screening and care

Children suffer physically as well as psychologically as a result of their experience as detainees and require
appropriate medical screening and treatment as an immediate priority following release. However, medical
treatment must be provided with the recognition that the child may have experienced torture or other abuse
under the guise of ‘medical procedures’, and it therefore may have extremely traumatic associations for the
child.

Coordination and Partnerships

UNICEF actions in support of child detainees should normally be carried out in close coordination and
cooperation with ICRC, DHA, UN Centre for Human Rights, and various concerned NGOs.

Promoting Recovery and Reintegration

UNICEF support should include the following broad inter-related strategies

- family reunification
- mobilizing and enabling the child’s existing care system
- schooling and vocational training
- psychosocial healing
- medical screening and care

The UN Centre for Human Rights: UNCHR has until recently had no presence in countries in emergency
situations. However, the Centre has now established programmes in Rwanda and Burundi and, funds
permitting, will likely start to become a regular presence in emergencies. The UNCHR field monitors are
potentially very important allies for the collection of information regarding the conditions of child detainees.

NGOs: Chief among NGOs that are potential allies are the members of the International Save the Children
Alliance (ISCA) who, like UNICEF, are turning increasingly to the CRC as a basis for their activities. Other
organizations and human rights bodies that have extensive experience in addressing abuses of children
include Africa Watch, the African Network on the Prevention of and Protection against Child Abuse and

ICRC: ICRC’s protection role stems from its mandate under international humanitarian law to help protect
civilians and other non–combatants and prevent attacks on their moral and physical integrity and cruel and
degrading treatment. In situations of armed conflict, the ICRC has a long history of acting to prevent abuses to
prisoners. Actions to promote the protection element of ICRC’s mandate include the monitoring of the
conditions of child detainees as well as advocacy to promote ratification of the Geneva Conventions;
dissemination of international humanitarian law, negotiations with parties to the conflict to ensure
humanitarian access; and overseeing the practical implementation of international humanitarian law.

OCHA: OCHA has an important role to play as an advocate for international humanitarian standards and the
rights of civilians. OCHA’s protection mandate includes the promotion of human rights, humanitarian affairs,
refugee laws and legal institutions; diplomatic efforts to enhance the safety of vulnerable persons or groups,
including child detainees; and the provision of an international presence to deter attacks and violations of
human rights and humanitarian law, and/ or to provide a measure of confidence and security for the victims.

Further Guidance

The Beijing Rules and the Ryadh Guidelines, UNICEF

Refugee Children: Guidelines on Protection and Care, Chapter 7, ‘Personal Liberty and Security’, UNHCR,
1994
Panel 1 – Detention of Children and Women Checklist for Field Visits

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<tr>
<th>DETENTION OF CHILDREN AND WOMEN CHECKLIST FOR FIELD VISITS</th>
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<tr>
<td><strong>General information:</strong></td>
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<tr>
<td>• Total number of children detained in that specific site</td>
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<td>and in other detention sites of the country.</td>
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<tr>
<td>• Age and gender breakdown of those figures.</td>
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<tr>
<td>• Number of imprisoned women/men with their child/children.</td>
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<td>• Number of imprisoned pregnant women.</td>
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<td>• Number of children released?</td>
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<tr>
<td>• Number of deaths of children, women and men in prison and</td>
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<tr>
<td>their causes.</td>
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<tr>
<td>• Age of criminal responsibility in the country.</td>
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<tr>
<td>• Collection of any specific legal provisions regarding the</td>
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<td>arrest, detention and transfers of children and women.</td>
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<td>• Obtention of official clearance from civilian and</td>
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<td>military authorities to visit detention sites.</td>
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<td>• Are there organizations such as ICRC or the Center for</td>
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<tr>
<td>Human Rights carrying out inspection or monitoring visits</td>
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<td>of detention sites?</td>
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| **Information regarding arrest of children:**              |
| • Reason for arrest.                                       |
| • When was/were the child/children arrested?              |
| • Is the child within the age of criminal responsibility? |
| • If not, can immediate release be obtained?              |
| • If not, can immediate conditional release be obtained?  |
| • Was arrest ordered by a competent police or judiciary    |
|   authority?                                              |
| • Was the child informed of the reason(s) for his/her      |
|   arrest?                                                 |
| • Was the family immediately informed of the arrest?      |
| • Are family/legal representatives allowed to visit the    |
|   child?                                                 |
• Does the child, or do children in general, complain about violence used during their arrest? Do other inmates/persons/ICRC teams? Have NGO teams reported violence or abuse of children during arrest?

• Is the UNICEF officer allowed to speak with children not privately in the presence of a prison official/guard?

• Was a judge immediately informed of the arrest and is the case being followed by a judicial authority?

Information regarding detention conditions of children:

• Are children detained in facilities separate from adults?

• Do children have regular contact with their families? If not, how can contact be made and maintained?

• Are there any unaccompanied children under the age of criminal responsibility?

• In case of separate facilities, do children have contacts with adult inmates during the day? During the night?

• How many meals do children have every day? Can the meals be considered as nutritionally adequate (support from UNICEF Nutrition officers or ICRC experts should be sought)? Are there obvious cases of malnutrition?

• What are the general conditions of hygiene? Cleanliness? Is there at least 1 latrine for every 50 detainees?

• Is there adequate water supply? (quantity and quality should be checked)

• Is there a periodic health monitoring system?

• If not, can the national health system be extended to include this detention site? If not, can ICRC include the site in its visits list? If not, can UNICEF provide emergency support and start the design of a referral system towards the local hospital or health centre?

• Are children minimally clad and protected against the weather?

• What is the average area available in the sleeping quarters? Consider 2.5 square metres in sleeping areas per child as the humanly acceptable minimum, not including recreational areas, washing areas or other.

• What is the average volume of air available per child?

• Are there any complaints of violence, abuse, torture against/between children (including sexual violence)? What subsequent actions were taken by the detention authorities?

• Are there reports of circulation of drugs and/or weapons inside the detention facility?

• Do children have access to educational activities?

• Do children have access to recreational activities?

• Are there compulsory activities, such as working for persons other than themselves e.g. preparation of food for guards or prison authorities, etc.? What are the activities carried out and what are the working conditions?

• Are there legal advisors/representatives of the child capable of defending her/him in court?

• Are the sentences or decisions applicable to children oriented towards the quickest release possible and their social reintegration?
Information regarding the detention conditions of pregnant women and women/men imprisoned with their children?

• Is there age–appropriate care for children in prison with their mother/father? Health and nutritional follow–up?

• Are there regular medical visits for women over seven months pregnant? And are provisions taken for delivery?

• Can children be placed back into their families, or with a relative, or fostered with the approval of his/her father/mother?

• What is the age limit for children allowed to be in prison with their parents? Is that age above three or four years? If so, can it be reduced?

• Are there any children in prison with their father/mother older than three years of age (or the maximum age allowed in the country)?

Information regarding transfers of children from one facility to another:

• In the case of transfers of children from one facility to another, are the parents and legal representative informed prior to transfer?

• Is any judicial authority present during the transfer?

• Are UNICEF, ICRC or Human Rights Officers present during transfer?

Chapter 13 – Annex 1: Juvenile Justice

Main provisions of the following instruments on juvenile justice:

• United Nations Rules for the Protection of Juveniles Deprived of Their Liberty, 1990


• United Nations Standard Minimum Rules for the Administration of Juvenile Justice (Beijing Rules)

The principles set forth in the UN Standard Minimum Rules aim to promote juvenile welfare and social rehabilitation of the juvenile offender. A child in conflict with the law has the right to treatment that promotes the child’s sense of dignity and worth, takes the child’s age into account and aims at his or her reintegration into society. The child is entitled to basic guarantees as well as legal or other assistance for his or her defense. The placement of a juvenile in an institution should be avoided whenever possible and detention should be a measure of last resort and limited to exceptional cases.

Basic Procedural Safeguards

• Presumption of innocence.

• Right to be notified of the charges, to counsel, to confront and cross–examine witnesses, to appeal to a higher authority, to privacy, to participate in the proceedings.

• Detention before the trial should be avoided to the extent possible, therefore efforts should be made to apply alternative measures.

• Right to facilities and services that meet all the requirements of health and human dignity,
and to adequate medical care, both preventive and remedial.

- All disciplinary measures constituting cruel, inhumane or degrading treatment shall be strictly prohibited, including corporal punishment that may compromise the physical or mental health of the juveniles concerned.

- Right to fair and humane treatment, including the right to visits, to privacy, to communication with the outside world.

Special Measures

Prevention of juvenile delinquency

- Societies have a responsibility to assist families in providing care for and in ensuring the well-being of children.

- Legislation and procedures to promote and protect the rights and well-being of all young persons.

- Legislation preventing the victimization, abuse, exploitation and the use for criminal activities of children and young persons should be enacted and enforced.

Juvenile justice administration

- Juvenile justice and detention facilities personnel shall be specially trained to deal with juveniles, as shall judges and police officers.

- Young persons and their families should be informed about the law and their rights and responsibilities under the law, as well as the universal value system, including United Nations instruments.

- Appropriate United Nations bodies, institutes and agencies should pursue close collaboration and coordination on various questions related to children, juvenile justice and the prevention of delinquency.

Deprivation of liberty

- The detention of juveniles should only take place under conditions that take full account of their particular needs, status and special requirements according to their age, personality, sex and type of offence, as well as their mental and physical health.

- In all detention facilities juveniles should be separated from adults, unless they are members of the same family.

- Upon the apprehension of a juvenile, his or her parents or guardian shall be immediately notified and have a right to be present.

- Detention, pending trial, shall be used as a measure of last resort and for the shortest possible period of time and shall be replaced by close supervision, intensive care or placement in a family.

- Every juvenile of compulsory school age has the right to education (provided outside the detention facility by qualified teachers) suited to his or her needs and designed to prepare him or her for return to society.
• Juveniles above compulsory school age who wish to continue their education should be permitted to do so.

• Juveniles in detention should have the right to a suitable amount of time for daily free exercise.


Article 1

Genocide, whether committed in time of peace or in time of war, is a crime under international law which State parties undertake to prevent and punish.

Article 2

Genocide is defined as any of the following acts committed with the intent to destroy, in whole or in part, a national, ethnic, racial or religious group, such as:

• killing members of the group
• causing serious bodily or mental harm to members of the group
• deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part
• imposing measures intended to prevent births within the group
• forcibly transferring children of one group to another group

Article 3

The following acts shall be punishable:

• genocide
• conspiracy to commit genocide
• direct and public incitement to commit genocide
• attempt to commit genocide
• complicity in genocide

Article 6

Persons charged with genocide shall be tried by a competent tribunal of the State in the territory of which the act was committed or by an international penal tribunal with respect to those contracting parties which shall have accepted its jurisdiction.

Chapter 14: Protecting Psychosocial Development

Rationale

Emergencies affect all aspects of a child’s well-being – physical, mental, social, and emotional – and assistance must take each into account. Emergency programmes traditionally have focused primarily on children’s physical well-being, however the psychosocial harm to children in disasters or violent conflicts is often just as great as the physical harm.
General Aim

Protect and restore the psycho-social well-being of children.

Supporting strategies aim to:

- promote the re-establishment of a stable family life;
- help re-establish a sense of normality in the child’s life;
- promote opportunities for expression of feelings;
- protect children from further harm;
- mobilize the child’s existing care system;
- train relief personnel on dealing with psychosocial issues;
- help to lessen the psychological impact of emergencies;
- enable children to be active agents in rebuilding communities and a positive future.

Children in emergency situations, particularly armed conflict, experience severely traumatic events such as:

- the violent death of a parent or close relative;
- being separated from family;
- witnessing loved ones being killed or tortured;
- participating in violent acts;
- being displaced from home and community;
- being exposed to combat, shelling and other life-threatening situations;
- being victims of acts of abuse – abducted, arrested, held in detention, raped, tortured;
- having school routines and community life disrupted;
- experiencing absolute destitution and an uncertain future.

These traumatic experiences have a sustained impact on children’s development (see Panel 1). Children’s psychosocial development is defined as changes in cognition, emotion, spirituality, and social relations mediated by socialization processes.

Children of all ages also are strongly affected by the stress levels and situation of their adult caregivers. Seeing a parent, who represents security and protection, being victimized leaves children feeling particularly fearful, vulnerable and defenseless. Once children have lost the protection of their family, or if the family is seriously weakened, they are vulnerable to a range of chronic secondary stress.

Psychosocial programming consists of structured activities designed to advance children’s psychological and social development and to strengthen protective factors that limit the effects of adverse influence. Beyond reaching individual children, the emphasis of psychosocial programmes is on strengthening children’s social supports, mainly the family and the community.

Guiding Principles

The Convention on the Rights of the Child (CRC) provides the guiding principles for UNICEF’s support to psychosocial recovery and well-being. The report of the expert appointed by the Secretary-General, Ms. Graça Machel, entitled The Impact of Armed Conflict on Children, identified a number of important guiding considerations in promoting psychosocial well-being and recovery, including the following:

Focus on healing: Rather than focusing on a child’s emotional wounds, programmes should aim to support healing processes. Key elements of healing include reintegrating the child into a stable and nurturing family environment, activating and enabling the child’s existing care system, re-establishing age-appropriate daily routines, including schooling, and providing the child opportunities for expression.

Understanding of cultural differences: Although many symptoms of distress have universal characteristics, the ways in which individuals and communities cope with, react to and understand stressful events can differ markedly from one culture to another and depend on social, political and economic contexts and different belief systems.

Understanding and respect for local traditions and practices: Those who wish to help with psychosocial healing should have a deep understanding of and respect for the societies in which they are working. Aside
from the basic principles of child development and local beliefs about children, they should also understand local culture and practices. This includes the rites and rituals related to becoming an adult as well as those associated with death, burial and mourning. They should be aware of what children are told about the death of their parents, how they are expected to behave when in distress, and how to respond to a girl who has been raped or to a child who has killed someone.

**Article 39 of the CRC states that:**

States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of:

- any form of neglect, exploitation or abuse;
- torture or any form of cruel, inhuman or degrading treatment or punishment;
- armed conflicts.

Such recovery and reintegration shall take place in an environment that fosters the health, self–respect and dignity of the child.

**Appropriate psychotherapeutic approaches:** Approaches based on Western mental health traditions tend to emphasize individual emotional expression, which may not be feasible in all contexts. Exploring a child’s previous experience with violence and its meaning is important to the process of healing and recovery. However, it should take place in a stable, supportive environment, by caregivers who have solid and continuing relationships with the child. In–depth clinical interviews intended to awaken the memories and feelings associated with a child’s worst moments risk leaving the child in even more severe pain and agitation. Listening closely to what children are saying, and observing their behaviour, are critical to an assessment, but must be done in an unobtrusive, non–threatening manner. Interviews must be conducted with on–going support for sensitive follow–up.

**Avoidance of institutional approaches:** Institutionalizing children and identifying them as traumatized can impose an inadvertent stigma and contribute to isolation and withdrawal. Building and placing children in expensive facilities is not a sustainable approach. The most effective and sustainable approach for promoting psychosocial well–being and recovery is to mobilize the child’s existing care system. When groups of vulnerable children, such as child soldiers, are targeted for special attention, it should be done with the full cooperation of the community so as to ensure their long–term reintegration.

**Assessment should focus on two main areas:**

- existing and potential psychosocial stress factors in the community
- existing and potential community–based mechanisms for promoting psychosocial well–being and recovery

**Community–led process:** Relief efforts can make matters worse if they reinforce a sense of powerlessness by treating those affected as helpless victims. Members of the affected community should be active partners in planning and carrying out relief efforts. Participation of the community has therapeutic benefits, helping to re–establish meaning and direction in people’s lives, enabling them to gain control over their situation, and raising self–esteem. Families and communities can better promote the psychosocial well–being of their children when they themselves feel relatively secure and confident about the future. It is particularly important that aid programmes include women at early stages, in making decisions about design, delivery and evaluation of initiatives.

**Involvement of youth:** Young people themselves should be involved in community–based relief, recovery and reconstruction programmes. This can be achieved through vocational and skills training that not only helps to augment their income but also increases their sense of identity and self–worth in ways that enhance healing. One way to give adolescents a sense of meaning and purpose is to involve them in implementing programmes for younger children.

**Identifying Priorities**

Identifying priority interventions requires a solid and objective assessment of the local situation. A thorough understanding of the local culture must be the starting point.
Assessment efforts should ideally be directed by or at least in consultation with the community itself. It is important to avoid sweeping assumptions regarding the extent and severity of the problem based on a few extreme cases that may not be representative of the population as a whole (see Panel 2).

It is not generally advisable to rapidly assess the proportion of children traumatized by the emergency, particularly by outsiders unfamiliar with the local situation and culture. It is not realistic for an outsider, even an experienced child psychologist or psychiatrist, to enter a community and identify children affected by trauma.

Field–Level Strategies and Actions

All phases of UNICEF programmes should take psychosocial considerations into account, and give priority to preventing further traumatic experience. Specific field–level strategies must always be adapted to the particular local situation, in accordance with the basic principles already mentioned and the results of assessment.

To facilitate the implementation of these strategies, attention must also be given to promoting and enhancing the capabilities of relevant local, national and other systems and authorities. Actions within each of these broad strategies are discussed below.

Re–Establishing a Stable Family Life

Sustaining and strengthening the family unit and, where necessary, reuniting families are the most important components in the psychosocial recovery and well–being of children. Children’s sense of well–being, resiliency and security is largely a product of how they experience daily life. To the extent they feel that their families are able to protect them and provide for their emotional and physical needs, their level of distress is likely to be reduced. The disruptions caused by an emergency undercut the ability of families to meet children’s basic needs. Many children experience a series of losses and require time to learn to trust adults again, overcome abandonment and regain confidence in themselves and the world. This is best achieved through a consistent, secure and loving relationship with a protective parent or adult. Areas of intervention may include the following.

Promoting family reunification: Being unaccompanied or involuntary separation from both family and community protective systems, greatly increases the child’s risk of exposure to violence, to physical abuse and exploitation, and almost always leads to distress. For children separated from their families, tracing family members and achieving family reunification or an alternative long–term care arrangement is an urgent priority. A nurturing foster family should provide interim care whenever possible and institutional care should be avoided (see Chapter 4, “Children Separated from their Families”).

<table>
<thead>
<tr>
<th>Strategies for psychosocial well–being:</th>
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<tbody>
<tr>
<td>• Reinforcing/reunifying families</td>
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<td>• Re–establishing a sense of normality</td>
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<td>• Providing opportunities for expression</td>
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<td>• Mobilizing and enabling the existing care system</td>
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<td>• Orienting and training relief personnel</td>
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<td>• Preparedness and preventive measures</td>
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Promote parental psychological healing: Parents who have themselves experienced trauma can at times be unresponsive to their children’s needs when they need them most. Helping parents deal with their own distress, and re–establish their capacity for good parenting, is vital to their own psychological healing and that of their children. Providing a safe group setting to share feelings with others with similar experiences has proven effective. Such groups may include associations for women, men, widows, families of missing persons, parents with tortured children, etc. It is preferable for these groups to have access to professional support (see Chapter 9, “Early Childhood Care and Protection”).
Promote parental awareness of psychosocial needs: Enabling parents with simple supportive techniques to help children cope with their fears, memories and distress is critical. Culturally appropriate suggestions on ways to talk with their children concerning their feelings and experiences, and to stimulate and play with withdrawn children, are especially important. Experience shows that parents are openly searching for this type of information. Training sessions, media activities, parent support groups, and outreach programmes are ways parents can be reached.

Promote family self-sufficiency: Providing income-generating opportunities helps family members to develop a sense of self-sufficiency, self-worth and control over their lives. Skills training, loan schemes, works projects, and animal husbandry programmes have all been successful in emergency situations. Such activities are especially important for traumatized youth, who often feel extremely pessimistic and unable to conceive of a future for themselves.

Ensuring adequate emergency shelter arrangements: Provisions must be made for the privacy and physical security of family units, and the integrity of belongings and personal space, especially if they must be used for more than a few days (see Chapter 16, “Supporting Shelter and Domestic Needs”).

Re-establishing a Sense of Normalcy

Familiar routines create a sense of security, purpose and meaning and also allow children to start functioning again as fully as possible. In addition to reinforcing and reuniting the family unit, areas of intervention may include the following.

Re-establishing schooling: Regular formal and informal schooling should be a priority from the earliest stages of an emergency, even in the absence of proper facilities or equipment. It is one of the most important means of restoring a sense of normalcy to the lives of children, and also provides them opportunities to form healthy peer relationships, acquire key life skills and knowledge, and build ongoing self-esteem. Education in emergencies is dealt with in detail in another chapter.

Creating recreational activities: It is important to create opportunities for organized non-violent play, sports and other forms of recreation. Establishing safe play areas for children to play and interact with their peers, free from violence and conflict is also important.

Resumption of cultural activities and traditions: Normal cultural activities and religious practices, including healing rituals and all forms of celebrations, help the entire community in introducing a semblance of normalcy in their lives. This is especially important for displaced populations, where such activities and traditions represent familiar and reassuring anchors in what may otherwise be a strange and threatening environment.

Providing nurturing opportunities for expression: Providing children opportunities and vehicles to tell their stories and to be heard and acknowledged is a critical part of the healing process. Letting children know they are not alone in their fears and experiences helps them to own and integrate such fears. It is particularly important to have an appropriate form of expressing grief and bereavement over the loss of family members, friends, possessions, culture, home or even country.

However, those working with or caring for distressed children should not force them to talk, write or convey more than they are able or ready to at any given time. A child will need to control the timing of such information and should never be pressured or coaxed to say more than she or he is able to at one time. Facilitators should also be responsible in their use of children’s drawings and writings. A child may be distressed if such personal expressions are shown to other people without permission.

Interventions designed to provide children the opportunity for expression may include the following.

Structured play activities: These provide a sense of normalcy and channels through which the child is able to express thoughts and feelings, both critical for the psychological healing process. Art activities – drawing, painting, working with clay, etc. may be particularly important for the young. Role-playing and children’s theatres are also important vehicles for children to express themselves. Skilled facilitators can increase the effectiveness and therapeutic value of play.

Group activities: Structured activities in group settings are often therapeutic, particularly for school-age or adolescent children. Groups offer children security and a safe place to learn and express themselves. Caution
should be exercised, however, in situations where the formation of a group may create security risks or carry a social stigma.

**Mobilizing the Child’s Existing Care System**

The child’s care system encompasses all of the caregivers the child comes into contact with, including parents, teachers, community health workers, social workers, youth leaders, religious leaders, traditional healers. Enabled with appropriate knowledge and skills, and building on existing cultural traditions for dealing with distress, they can play an important role in promoting children’s psychological healing and recovery, and in rebuilding the child’s ability to trust.

<table>
<thead>
<tr>
<th>Benefits of Group Activities</th>
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<tr>
<td>• affords opportunities to establish healthy peer relationships;</td>
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<td>• allows children to see how others with similar feelings and problems react to problems;</td>
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<tr>
<td>• helps children to learn steps for problem solving;</td>
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<tr>
<td>• offers a structured setting, where children know the rules and can practice successful interactions with others their age.</td>
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It is generally not effective to build a parallel institutional system, which encourages the segregation of children from their existing care system. Nor is it appropriate to depend on specialized outsiders to treat the small percentage of children who become severely traumatized and require special attention and care. It is unlikely that such an outsider will be able to understand the cultural factors contributing to how the child experiences and communicates feelings or will be present long enough to follow through with the child’s treatment. Healing should be promoted within the framework of the child’s existing care system to the maximum extent possible.

Interventions designed to mobilize and enable the child’s care system may include the following:

**Teacher training:** Teachers are often very effective vehicles for helping distressed children, provided there is no conflict between the ethnic or political background of the teacher and the children. They are generally interested in improving their skills to deal with psychosocial difficulties of children. Teacher training should focus on:

- understanding the nature, causes and effects of traumatic stress and how this appears in the behaviour of children;
- how to organize classroom and recreational activities – to create a safe environment and avoid further stressful events in the classroom;
- when and how to use other mediums such as writing, drawing, story telling, dance or drama to express feelings and assist children in integrating past events;
- how to identify and enlist the support and help of other adults who come into contact with children in need, such as parents, community workers, health workers, religious teachers, or traditional healers;
- how to prepare a plan of action for those children who are severely traumatized and will require special individualized or small group help.

**Support/training for health personnel:** Although often not equipped or trained to handle psychosocial problems in an emergency, health personnel are frequently faced with stress–related disorders. Training, special programmes and technical support are therefore often required by health personnel. Collaborative referral systems can be developed linking health personnel with other members of the child’s care system, such as traditional healers, more equipped to deal with some psychosocial difficulties.

**Other specialized training and mobilization activities:** Training programmes, tailored to various categories of child caregivers are often useful for raising awareness. These should address topics such as listening skills, common distress symptoms, needs created by traumatic experiences, and ways to facilitate psychological healing. Youth have successfully run initiatives for children such as peace camps and youth counselling programmes in a number of countries, promoting the self–esteem of all.
Psychosocial support for adult care-givers: Adults in the child’s care system have often themselves been affected by trauma. Part of enabling them to help children is providing opportunities to come to terms with their own experiences. Support groups have proved useful in many emergency settings.

Informing and Training Relief Personnel

All relief personnel – national and international – must understand that their own behaviour towards the children, parents, teachers, community leaders and others with whom they come into contact has a direct affect on the psychological and emotional well-being of those individuals. They have a critical impact on the children and adults who have undergone traumatic experiences. Relief workers must:

- understand what the population has experienced and how the people have been affected;
- realize that individuals who have experienced traumatic events may have difficulty in concentrating, suffer intrusive memories or experience other disturbing symptoms. Workers must establish realistic expectations for, and consider the vulnerability of, such people;
- be trained or experienced as a sympathetic listener, to maintain appropriate boundaries and conduct with vulnerable individuals who are dependent on them for services, and to practice and maintain standards of ethical conduct;
- consciously avoid adding to the existing trauma/distress of those with whom they are in contact, especially children.

Special programmes and measures are often necessary for relief workers themselves to counteract work pressures, prevent ‘burnout’, help them deal with their own distressing experiences.

Preparedness and Preventive Measures

<table>
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<tr>
<th>Psychosocial support training can include the following:</th>
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<tr>
<td>• training session that make direct use of experiences, issues and problems of the staff;</td>
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<tr>
<td>• regular changes of scene for locally hired staff, including visits to family members;</td>
</tr>
<tr>
<td>• participation in meetings and exchanges with counterparts in programmes elsewhere that serve to upgrade skills, analyse lessons learned and generally assist rather than hinder staff to aid a child’s healing process.</td>
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During the early stages of an emergency when there is risk of further major disruption, preparatory actions must be promoted at family and community level to lessen the psychological impact.

- Families and teachers may prepare children by discussing the situation and possible outcomes (such as evacuation) with them.
- Families and communities and/or local authorities may anticipate outcomes and take measures to protect and minimize the potential suffering of children while preserving family unity.

Panels

Panel 1 – Common Psychosocial Distress Signs in Children

<table>
<thead>
<tr>
<th>COMMON PSYCHOSOCIAL DISTRESS SIGNS IN CHILDREN</th>
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<td>When children have been exposed to ‘events beyond the normal boundaries of human experience’, that is, traumatic or psychologically wounding events, all kinds of stress reactions will be apparent – normal responses to abnormally distressing events. The nature of these stress reactions will depend on the type of</td>
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traumatic event, the frequency and length of exposure, and the individual characteristics of the child survivor (i.e. age, sex, personality type) as well as the child social environment (family support, community network, culture, etc.).

While there are cultural variations, psychological distress or trauma generally impacts children by limiting their ability to engage in the world around them and to participate in routines such as school and play. A common first sign of distress is a child’s not interacting with others or not expressing curiosity in his or her surroundings. Traumatic events can also bring about extremes of behaviour, such as being too aggressive or even too obedient and ‘good’ (passive). Children exposed to repeated violence and other traumatic experiences may also experience a change in their beliefs and attitudes, including a fundamental loss of trust in others. Other manifestations may be nightmares, inability to sleep, repetitive or disturbing play, and difficulties in concentrating and sitting still.

Distressed children may regress in behaviour, particularly at younger ages. For example, an infant who slept through the night may no longer do so; a toddler who was toilet trained may return to soiling his/herself for a period of time. Older children may revert to play from a younger age, resume an old habit such as thumb sucking or rocking, or become more dependent and fearful of separation from the parent or caregiver. Adolescents can be particularly vulnerable when the gradual gaining of independence from the family is disrupted.

Response to trauma can be immediate or it can be delayed for weeks, months or even years, and different children will cope differently. While all children are deeply affected by their experiences, not all children will be able to show their distress until some degree of stability and security are established within their environment; thus delayed reactions are common. Without appropriate and timely care and the creation of a safe environment for the expression of past trauma, their experiences may emerge later in life with a profound effect on their adult development.

Panel 2 – Assessment Checklist

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<th>ASSESSMENT CHECKLIST</th>
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<tr>
<td>Specific survey methods will depend on the local situation and culture. The following represents the type of information useful for addressing issues of psychosocial well-being and recovery.</td>
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**General conditions**

- Were situations of violation of children rights at the origin of traumatic events?

- Have situations of abuse stopped or are they still continuing to create a climate of insecurity for the children and their families?

- Are families living together?

- Do they have sufficient privacy?

- What is being done to enable families to live in dignity and provide care and protection for their children? What more can be done?

- What are the normal activities in the community to assist children who have difficulties?

- What are the community’s normal mechanisms to respond to and deal with psychosocial distress? How can they be strengthened and built on?

- How do the general living arrangements and social organization of the population affect the protection and care of children?

- What measures could be implemented to improve the living conditions of the children and their families?

- Are there persons in the community who could provide regular activities for the children such as non–formal education, play and recreation?
Parents

• What is the nature of hardship and stress that parents face that are affecting their well-being as well as how they care for their children?

• What measures can be implemented to reduce this hardship?

• Are parents seen beating their children more than is normally permissible within their cultural framework?

• Are there opportunities in place for parents to discuss and seek support for distressing difficulties that they and their children must deal with?

Children

• Are children being provided adequate nurture and care?

• What measures might be taken to improve the care that such children receive?

• Are there children who are alone?

• Are there children who are behaving in an aggressive and violent manner?

• Are children provided culturally appropriate opportunities to talk about concerns, ideas and questions that they have?

• Do children have the opportunity to play?

• Are the special needs of unaccompanied children, long-stayers in camps and children in confinement being addressed?

Services

• Are education and other activities provided so that children are able to participate in regular development-enhancing activities and re-establish a sense of routine?

• Do refugee adults and children have access to social services to help address difficulties?

• Are systems in place to identify and assist children experiencing psychosocial distress?

• Is training and support being provided to teachers? Are primary health care and other service personnel available to help them better support children?

• Do specialized mental health services exist to which children in severe distress might be referred?

Adapted from Refugee Children, UNHCR, 1995

Chapter 14 – Annex 1: Copyright of Original Art/Writings Created by Children

Advisory for Social Workers and Communicators

Given the growing interest by media, specialists and the general public in the role played by the creation of visual and written artworks in trauma treatment, it is important to understand the legal and ethical issues involved. Like everyone else’s, children’s artwork cannot legally be reproduced without their consent. It is therefore important that UNICEF staff or other people working with children who are creating art, particularly in trauma treatment programmes, help protect their artwork from collection, distribution or reproduction without
their consent.

Additionally, any children’s artwork in UNICEF’s possession should be accompanied by a copyright release form giving UNICEF permission to reproduce the work internationally (for minors, this release must be signed by their parental guardian or the adult guardian – teacher, counsellor – legally responsible for the children at the time the artwork was created). If this permission has not been obtained, the artwork should not be offered to any media – photographers or publishers – for reproduction.

A copy of a sample release form is attached.

COPYRIGHT RELEASE FORM

For the purpose of promoting peace, tolerance and children’s rights, I hereby grant to the United Nations Children’s Fund (UNICEF) the right to reproduce, display and disseminate worldwide and in perpetuity, in publications, exhibitions and all other media forms including electronic, the drawings and writings (including their translation into any other language) made by children while under my care and/or authority in educational or therapeutic settings.

(If person is not the parent or legal guardian of the child/ren concerned): I further confirm that I am the authorized representative of the organization named below, which is acting as the temporary guardian of the child/ren, at the location stated below, in the absence of their parental guardians.

Drawings and/or writings covered by this release form:

<table>
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<tr>
<th>Description/Title of Work</th>
<th>Creator’s name</th>
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<th>Location</th>
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Print name of Parent/Guardian or Authorized representative* (circle one) Signature

(*Authorized representative, add title and name of organization)

Print name of: Witness/Occupation/Institutional affiliation

Signature

Chapter 15: The Impact of Sanctions

Introduction

The United Nations Charter confers on the Security Council primary responsibility for the maintenance of international peace and security on behalf of Member States. Accordingly, the Security Council decides what measures including those not involving the use of armed force are to be employed to give effect to its decisions necessary to maintain and restore international peace and security, and calls upon the Member States to apply such measures, including complete or partial interruption of economic relations (See Charter Articles 24, 39 and 41). Regional bodies and individual states may also impose sanctions.

In principle, sanctions are imposed with the positive aim of changing the behavior of the targeted government or opposition groups. For instance, arms embargoes have been used in situations where war and political
upheaval have forced children to grow up in the midst of violence, as in the case of Former Yugoslavia, Angola, Federal Republic of Yugoslavia, Haiti and Rwanda, to name a few. Particularly, given the proliferation of light weapons in armed conflicts, which encourage a frightening escalation in the involvement of children as fighters, arms embargoes may have a positive role in protecting children in armed conflict. Sanctions have also sought to reduce the flow of resources that directly fuel armed conflicts and, therefore, prolong the deadly threats to children. Such has been the case of bans on illicit trade in diamonds in Angola and Sierra Leone.

Despite such potentially positive roles, sanctions, especially broad economic sanctions, are a blunt tool. They can and have resulted in considerable hardship for the targeted country’s population, with the poor and the vulnerable – particularly children and women among them – being the hardest hit. In the three years of sanctions in Haiti, the rate of malnutrition for children under five almost doubled. In one particular rural area of Haiti, child mortality increased by up to 64% in the two years after the imposition of sanctions. In Iraq, which has been under economic sanctions since 1990, – the most comprehensive sanctions ever imposed by the UN – children under five have been found to be dying at more than twice the rate they were 10 years ago. One in five children in Iraq\footnote{1} are reported to be malnourished.

\footnote{1} Not including the three autonomous governorates in Northern Iraq.

The importance of the fact that provisions of human rights and international humanitarian laws are fully applicable to states under sanctions could not be overstated. Thus, the sanctioned state has a legal obligation to respect the civil and political rights of its citizens and the international community is under a similar obligation to do everything that it can to protect the core contents of the economic, social and cultural rights of the people of the affected country.\footnote{2} The Security Council, in turn has an obligation to ensure that proper implementation of sanctions does not result in violations of human rights and humanitarian laws.\footnote{3}

\footnote{2} General Comment Number 8, the Committee on Economic, Social and Cultural Rights (E/C.12/1997/8).

\footnote{3} Issue Paper Concerning the Sanctions Imposed by the Sanctions Committee, Chairmen of the Sanctions Committee, 30 October, 1998.

**Guiding Principles**

The following set of general principles has been proposed to guide UNICEF policy on sanctions.

- The Convention on the Rights of the Child should be the legal and moral basis in addressing situations of children under sanctions. The protection of the rights of children and the primacy of their best interests should be treated as a central principle in all actions concerning children in the context of sanctions.

- The objectives and form of sanctions should be consistent with the UN Charter, international law and widely accepted values and principles of conduct in international relations.

- Whenever possible, sanctions should be precisely targeted at the vulnerabilities of those whose behavior the international community wishes to change. Partial sanctions, such as an arms embargo or the freezing of overseas bank accounts, are preferable to comprehensive economic sanctions, which should be viewed as a last resort.

- Whenever sanctions are imposed, they should be designed in such a way so as to minimize the negative impact on vulnerable groups, especially children and women.

- There should be a Child Impact Assessment before the imposition of sanctions and constant monitoring thereafter to gauge humanitarian impact.

- Sanctions legislation should include a definite humanitarian commitment by the international community to respond to any disproportionate suffering experienced by vulnerable groups residing in sanctioned countries.
Minimizing Humanitarian Impact of Sanctions

Practical recommendations to minimize the negative humanitarian impact of sanctions on civilians have been presented through various fora including the UN. Most converge on the following points.

Pre-Assessment and Monitoring

Sanctions should not be imposed without first conducting an assessment and analysis of the economic, social and political situation in the target country. This assessment should measure civilian vulnerability, anticipate likely humanitarian impact, and provide guidance to the Security Council for formulating sanctions legislation to better protect the vulnerable. (When sanctions are imposed on an urgent basis, pre-sanctions assessments may not always be feasible.)

A Child impact Assessment should be undertaken at the point at which any set of sanctions is applied, as part of a broader Humanitarian Impact Assessment, which would examine the vulnerabilities and potential impacts of sanctions on different sectors of the targeted population.

Once sanctions are imposed, the UN should establish an effective ongoing monitoring system for measuring the humanitarian impact of sanctions on children and other civilians. Such system of monitoring could detect and provide early warning of civilian distress, and guide necessary humanitarian action to address the problem. The UN should take into account the results of Humanitarian Impact Assessments and monitoring when reviewing sanctions and should adjust or repeal sanctions if they are shown to be causing serious harm.

More specific recommendations include among others,

- The UN should facilitate the development of a rigorous methodology to evaluate the humanitarian impact of sanctions.
- Monitoring could be implemented by UN agencies and programmes and/or neutral, independent bodies, such as NGOs linked to academic centers.
- The UN could appoint a Working Group or a Special Rapporteur to monitor the humanitarian effects of sanctions. A group of “humanitarian monitors for sanctions”, similar to the current UN human rights monitors, could also be considered for being dispatched to countries as soon as sanctions are imposed. Such a group could provide ongoing surveillance of the situation, alerting UN authorities to dangerous or deteriorating humanitarian conditions.
- A separate unit could be created, for example, within the Department for Economic and Social Information and Policy Analysis, to deal specifically with sanctions. Similarly, an administrative focal point for sanctions assessment and monitoring could be designated within the Department of Humanitarian Affairs, which is already mandated to alert the Security Council to humanitarian concerns in sanctioned countries. The Inter-agency Standing Committee (IASC) might consolidate data and reports on humanitarian conditions in sanctioned countries.
- Humanitarian organizations, including NGOs, as well as academics and other interested parties, should be encouraged and assisted in their efforts to monitor and report on sanctions.
- Impact studies should also consider longer-term structural effects of economic sanctions.
- The negative economic effects of sanctions on third-countries should also be closely monitored. Steps should be taken to minimize or otherwise compensate for these negative effects.

Humanitarian Exemptions

Sanctions should not impede the work of humanitarian organizations providing assistance to the civilians of the targeted state and adequate humanitarian exemptions must be provided for in the sanctions regimes.
Humanitarian exemptions have basically included food and medicine, and other “items of humanitarian need”. Most exemptions have been subject to Sanctions Committee approval on a case-by-case basis. In the case of economic sanctions on Burundi, the list of humanitarian items grew from medicine and emergency food to include all food and food products, medicines, items relating to education, and construction and agricultural materials. In the case of Iraq, through the Oil-For-Food-Programme, the humanitarian exemptions now cover items ranging from food, medicine and items related to education to those related to the rehabilitation of the infrastructure, including electricity, telecommunications and oil industry.

Footnote 4 Based on the recommendations made in the Report of the Second Panel established pursuant to the Note by the President of the Security Council of 30 January 1999 (S/1999/100), concerning the Humanitarian Situation in Iraq (Annex II of S/1999/356) and Pursuant to the Security Council Resolutions 1284 and 1302, a list of items have been approved by the Security Council, for which circulation to the Sanctions Committee for approval is no longer required. Such items are approved by the UN Secretariat, with notification to the Sanctions Committee. The items cover those related to food, education, agriculture, health, oil sector and basic water and sanitation.

The Security Council has yet to define what constitutes “humanitarian needs”. At least one lesson from Iraq has been that the humanitarian exemptions based solely on the provision of supplies and equipment have fundamental limitations. From the perspective of UNICEF, the definition of “humanitarian needs” should move beyond those concerned with physical survival and food. Humanitarian exemptions should give equal attention to enabling the fulfillment of rights as guaranteed by basic international human rights and humanitarian laws, and children’s rights, in particular, as stipulated in the CRC. Humanitarian exemptions, therefore, should be expanded to cover requirements for education and child protection, among others. In the particular case of comprehensive economic sanctions, exemptions should also provide for a modicum of income and employment for the population.

Measures proposed to improve the current humanitarian exemptions include:

- Exempt humanitarian assistance programmes of the UN agencies and NGOs from required approval by the Sanctions Committees.
- Adopt a “Reference System” in place of the current Case-by-Case approach by the Sanctions Committees, by which only exceptional or questionable cases would be forwarded for approval.
- Publish lists of “essential civilian supplies” as well as all Case-by-Case approved/ refused exemptions.

Capacity Building

UN Security Council, Secretariat, Agencies & Programmes and international and national NGOs should strengthen their capacity to better assess and monitor the humanitarian impact of sanctions.

Improving the Sanctions Regime

As mentioned earlier, comprehensive economic sanctions should be viewed as a last resort. Rather, sanctions should target the perpetrators of aggression and minimize its effects on innocent victims. Therefore, priority should be given to the least damaging, but still effective, measure that avoids disproportionate harm to civilian populations. Such measures, or partial sanctions, might include an arms embargo, freezing all corporate and individual overseas assets, stopping certain kinds of economic transactions, suspending air links and other forms of communication, restricting travel, and isolating countries from the rest of the world through cultural, academic and economic boycotts.

In addition, sanctions should be viewed not simply as a punitive measure, but also capable of inducing positive change. Sanctioning authorities might consider offering carefully considered incentives to reward compliance by targeted regimes.
Role of UNICEF Field Office in Countries under Sanctions

Whether and how sanctions are going to be imposed is a political decision and, as a result, much of the implementation of the above-mentioned recommendations depend on the will and action of the Security Council.

However, UNICEF field office and headquarters must centrally be involved in sanctioned countries because, as mentioned earlier, sanctions have the greatest impact on the vulnerable children.

Contribution to Pre-Assessment and Monitoring

UNICEF can and should participate in any Humanitarian Impact Assessment that takes place, ensuring that the specific needs of children are taken into account through the Child Impact Assessment, particularly in respect of the Security Council Resolution 1261 (1999) on Children on Armed Conflict. If the Security Council requests such assessment, it will most likely be on very short notice, requiring a readily available methodology, mechanism and human resources. It would be advisable for the headquarters to develop a roster of individuals who could participate in sanctions assessment/monitoring missions. When sanctions are imposed on an urgent basis without a pre-assessment, UNICEF field office should take the initiative to carry out Child Impact Assessment immediately after the imposition of sanctions.

Thereafter, the UNICEF field office should monitor changes to humanitarian situations affecting children and women, brought on since the imposition of sanctions. The UNICEF field office should encourage the participation and input by neutral, independent bodies such as NGOs linked to academic centers in the pre-assessment and monitoring exercises. In addition, given that governments are major partners of UNICEF programmes, the information from and expertise of government agencies and related academic institutions should not be discredited in the pre-assessment and monitoring exercises. However, to avoid politicization of data thus gathered, UNICEF field offices should have a mechanism in place to ensure as much as possible the credibility of government-source data and analysis.

What Should be Measured? How?

There is yet to be a universally accepted methodology for conducting pre-assessment and monitoring of humanitarian impact of sanctions. However, UNICEF already has several good in-house tools. Among them is a set of child-focused, sanctions-sensitive indicators. Most of these indicators are normally found within the UNICEF field office’s information system as part of regular programmes.


• infant and child mortality and morbidity rates;
• incidence/prevalence of vaccine-preventable diseases;
• vaccination coverage;
• nutritional status for children under five;
• primary school enrolment rate;
• access to safe water;
• data on vulnerable groups and destitute;
• trends in food prices
• dependency on export/import for basic food and essential services

Footnote 6 These indicators are by no means an exhaustive list. Trends that ca be observed – if not with established indicators – such as incidents of child abuse, the number of women-headed households, the number of working children and street children, and the number of persons attending outpatient clinics for mental and psychological disorder, may provide a valuable qualitative insight into the deteriorating social texture of the country under sanctions and the situation of its children.

Data required for pre-assessment and monitoring by UNICEF field offices may not be different from what is used by UNICEF under normal (non-sanctioned) conditions. When sanctions are applied, however, it is
important that UNICEF field office has the capacity to quickly adjust and fine−tune its information system so as to monitor the effects of sanctions most efficiently and effectively.

**What Limitations or Difficulties Should be Anticipated?**

First of all, UNICEF field office has to acknowledge that there is no rigorous−enough methodology available to disaggregate the effects of sanctions from other causes of hardship. The best that UNICEF field office could do is to conduct, in consultation with EPP, PD and EMOPS as necessary, a reasonably accurate assessment of additional or compounded humanitarian hardship brought on since the imposition of sanctions.

Secondly, household surveys and community level data are the best sources for assessing humanitarian effects of sanctions, particularly for child mortality. However, such methodology can be a challenging exercise, especially if the field office has insufficient resources, both material and human.

Thirdly, data gathering, particularly at the household level, can be a significant challenge under highly political sanctions environments. The sanctioned government could suspect that the results might be used against it; the international community could discredit results, which are based on data gathered by local interviewers. There is no easy answer to this. As seen in the example of UNICEF Iraq, in its Child and Maternal Mortality Survey of 1999, every possible angle of the exercise, both in methodology and process, should be fully scrutinized to ensure accuracy and reliability of data and results.

### Advocacy

Through various fora and equipped with objective data, UNICEF field offices, in coordination with headquarters, can advocate for measures that can help alleviate the harsh humanitarian impact of sanctions.

#### Advocacy for Targeted Sanctions

UNICEF should advocate for targeted sanctions, different types of which have been mentioned earlier. Targeted sanctions are designed to more directly affect those responsible for the breach of peace, while leaving the innocent civilian population alone. Therefore, properly targeted sanctions may minimize the suffering of civilians including children, while putting significant pressure on the responsible parties, thus bringing the sanctions regime into compliance with human rights and humanitarian laws.\(^{7}\)

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#### Advocacy with Security Council

Objective information on the humanitarian situation provided by UNICEF field office can form a powerful argument with the Security Council to make necessary adjustments to the scope of humanitarian exemptions in the sanctions regime. Similar data should also be used to call for immediate approval by the Sanctions Committees of items of critical importance to public health, which are put on hold for reasons of possible dual use by the military.

UNICEF Iraq provides a good example of how the Executive Director and the Country Representative can be involved in a sustained manner to bring advocacy to the highest political level, including the Security Council, the Sanctions Committee and various Member States. On various occasions they have brought to the above−mentioned bodies, in person, an objective picture of the situation of Iraqi children, pushed for specific changes to the modality of humanitarian exemptions, advocated for protecting the most seriously disadvantaged children within Iraq and urged the Sanctions Committee to lift holds on essential water and sanitation equipment and supplies that were gravely undermining the health of Iraqi children.

#### Advocacy with the Targeted Government

UNICEF field office in coordination with the headquarters must advocate with the targeted government of its own responsibility toward its children. UNICEF Iraq, for instance, has consistently called on the Iraqi government for the need to assist vulnerable children and to adopt targeted nutrition programme for malnourished children. (The targeted nutrition programme is in place now.) UNICEF Iraq is also calling on the
政府应将母乳代用品从政府食物配给中移除，并替换为针对怀孕和哺乳期妇女的额外食物，同时促进纯母乳喂养作为其国家政策。

**Advocate for Long-term View of Vulnerabilities**

UNICEF必须领导并推动关于当前儿童困难长期影响的讨论。它必须推动国际社会考虑一整代儿童被剥夺接受适当教育和信息的后果，以及成年结果将因当地工业和公共部门经济的损失而失去宝贵的生产力技能。保持这样的讨论也可以为为什么人道主义例外仅限于食品和药品不能防止不可逆转的儿童损害提供论据。

**Capacity of Field Offices**

如前所述，UNICEF区域办公室收集和分析数据以及维持有效监测系统的容量存在显著差异。数据和信息资源的质量也存在巨大差异。

为了最大限度地提高UNICEF的信息收集、评估和监测能力，需要检查该组织当前的地区级信息系统和数据库。持续或增强这些指标的收集和分析将对更全面的制裁评估做出重要贡献。

UNICEF区域办公室的能力也可以通过动员独立观点和分析，这些观点和分析由学者、NGOs、受影响群体和其他感兴趣方提供。这些团体可以提供技术专长、评估能力和客观分析制裁影响的工具，相对较少受机构冲突、利益和官僚主义的限制。

**Conclusion**

保护生活在受制裁国家的儿童权利伴随着所有级别的组织面临的挑战。区域办公室必须应对紧迫的需求，这些需求完全由安理会制裁委员会批准，以提供基本服务。总部必须参与与安理会和被制裁政府的政治谈判，常常在组织的使命和安理会的决定之间寻找微妙的平衡。

最后但并非最不重要的是，UNICEF应该认识到区域办公室工作人员面临的特殊挑战。他们被要求在特别具有挑战性的环境下提供服务。然而，制裁环境特别可能限制信息和同事的访问，尤其对本地工作人员来说。每个工作人员在个人层面上必须面对的道德两难必须被充分认识到。提供正式和非正式的渠道来表达这些担忧、挫折和问题，应该始终为组织提供支持，以鼓励工作人员之间的相互支持。

**Chapter 15 – Annex 1: Reducing the Negative Humanitarian Impact of Sanctions**

“让我结束时说，人道主义局势在伊拉克构成了一个严峻的道德难题。联合国一直站在脆弱和弱势的一边，并一直寻求减轻痛苦。然而，现在我们被指责正在对整个人口构成痛苦。

“其实，理事会应该寻求一切机会减轻人口的痛苦。毕竟，他们不是制裁的目标。”

**Secretary General Kofi Annan**, 24 March 2000, addressing the Security Council at its 4120th Meeting
“In the interests of children, sanctions should not be imposed without obligatory, immediate and enforceable humanitarian exemptions, along with mechanisms for monitoring their impact on children and other vulnerable groups. ... We believe that child–impact assessments are central to this and should be carried out before, during and after sanctions are imposed.”

Executive Director Carol Bellamy
addressing the Security Council
in February 1999

“I would recall Article 3 from the Convention of the Rights of the Child, which sets out that in all actions concerning children... the best interests of the child shall be a primary consideration... I urge that the protection of the rights of the Iraqi children and the primacy of their best interests be treated as a central principle in the on–going dialogue between the international community and Government of Iraq.”

Executive Director Carol Bellamy
addressing the Security Council
in October 1999

“The fact that basic humanitarian needs are being met through hand–outs does not contribute to stimulate the economy and has an indirect negative impact on agriculture, while increasing State control over a population.

“Foodstuffs, pharmaceuticals and medical supplies, as well as basic or standard medical and agricultural equipment and basic or standard educational items included in a list of exempted humanitarian supplies, pre–approved by the 661 Committee ... should be contracted and procured ... without any requirement for approval or notification to the 661 Committee.

“International organizations and NGOs should be encouraged to provide published materials of an educational character to Iraq. Greater access to the international media and to imported publications in general should be promoted. Additional measures aimed at reducing the isolation of Iraqi educators, health care providers, students and others should also be considered.

“The Government of Iraq should address effectively the needs of vulnerable groups in the Center/South, especially those of street children, the disabled, the elderly and the mentally ill, among others, and allow freer access to UN agencies and recognizably impartial and bona fide NGOs from restricted areas and sections of populations for adequate evaluation of their nutritional and general humanitarian condition.”


“The potential long–term benefits of sanctions should be weighted against the immediate and long–term costs to children, including the collapse of health and education infrastructures, reduced economic opportunities and increased child labor in informal sectors, increased infant morbidity and mortality.

“When imposing measures under Article 41 of the Charter, the Security Council is urged to develop a coordinated and integrated approach to minimize unintended consequences on civilian populations, especially children, primarily through the establishment of effective, humanitarian exemptions. To this end, the Council could consider authorizing assessment missions to the targeted states and neighboring countries before sanctions are imposed, with the aim of assessing the likely unintended consequences of sanctions and proposing appropriate measures to minimize such consequences and effective monitoring measures.

“When adopting measures under Article 41 of the Charter, the Security Council is urged to reaffirm the responsibility of targeted States and armed groups to ensure the humanitarian protection of all those under their control, particularly children.”

Report of the Secretary General on Children and Armed Conflict
Chapter 16: Human Rights SITAN

Here is the original presentation:

February 14, 2001

ADAPTING SITAN TO HUMAN-RIGHTS BASED PROGRAMMING
Key Points for Discussion

The Situation Assessment and Analysis involves the study of an individual in its environment socio-economic, political, civic and cultural. It has two components:

Assessment Phase:
- Identifies and describes existing problems faced by women and children in a given environment with respect to their rights

Analysis phase:
- Analysis key problems identified from the assessment and focuses on the underlying causes highlighting different levels of determinants (immediate, underlying, and structural)
- Identifies key actors and institutions with responsibility for promoting women and children’s rights
- Identifies potential resources needed to achieve the full realisation of Human Rights
INCREASE EMPHASIS ON THE REALISATION OF HUMAN RIGHTS
From needs based to rights based

Gradual realisation by the international community that the respect for human rights are crucial for sustainable human
• Global political changes
• UN reform

Increase focus on the United Nations Charter and the Universal Declaration of Human rights

Focus away from needs based approach to rights based approach.
• Wholistic approach to development (child, woman as subject
• Individual central to development in his or her own right
• Recognising the equality of each human being and their right to self determination, security etc.

• Example: Rape of a girl:
  - needs approach - attention to the girls medical needs
  - rights approach - responsibility of different actors and institutions

• Analysis from a rights perspective should lead to a mix of causes that together prevent the enjoyment of rights.
KEY DOCUMENTS FOR USE IN PREPARATION OF SITAN

Convention on the rights of the child (CRC)

Convention to Eliminate all Forms of Discrimination Against Women (CEDAW)

Other regional and International Instruments (African Charter)

International conferences
THEORETICAL CONCEPTS USED FOR SITUATION ANALYSIS
Need to Translate into Operational Tools

- Human Rights Principles
  - Universality/Non-discrimination
  - Interdependence
  - Indivisibility

- CRC Foundation Articles
  - Non-discrimination
  - Best interest of the child
  - Right to life, survival, development
  - (Respect for views of the child)

All key actors are accountable to uphold these rights (including CRC and CEDAW)
TRANSLATING THEORETICAL CONCEPTS INTO OPERATIONAL TOOLS (1)
Example of Tools/Approaches

Universality/Non-discrimination

Non-discrimination on the basis of colour, race, gender, language, origin, opinion, disability

Special focus on most vulnerable groups (handicapped children, pygmies, urban and rural poor, slavery)

Attention to gender equality and equity between age groups

Disaggregated indicators for CRC and CEDAW
- Age, gender, locality, etc.

Life cycle approach
- Extent and focus on target population
  - 0-60 women and children

Studies and research
- Problems affecting the realisation of women and children's rights

National legal frameworks
- Constitutions
- Family code
- Penal code
- Labor laws, etc
TRANSLATING THEORETICAL CONCEPTS INTO OPERATIONAL TOOLS (2)
Example of Tools/Approaches

- Holistic approach to analysis and assessment
  - Including vulnerability analysis
- Women and children as subjects analysed in their environments, not separately
- Complementarity of rights between
  - Parents and children
  - Girls and women
- Multisectoral approach/team to prepare the SITAN
- Move beyond UNICEF traditional areas of intervention
  - Maternal health linked with economic, political, civic rights
# Accountability of All Key Actors to Uphold Human Rights

Including CRC and CEDAW

<table>
<thead>
<tr>
<th>States</th>
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<tr>
<td>Obligation to uphold rights, monitored through</td>
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<tr>
<td>- CRC and CEDAW reports and committee recommendations</td>
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<tr>
<td>- Linking national policy and global conferences</td>
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<td>- sectoral-based (education, nutrition, population, settlements, etc.)</td>
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<tr>
<td>- child protection (Stockholm, Amsterdam and Oslo)</td>
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<td>- human rights (World Conference)</td>
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<td>- women's rights (Beijing)</td>
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<td>- National policies and their consistencies through human rights conventions</td>
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<tr>
<td>- Social service expenditure through 20/20 initiative, fiscal policies and distribution of general spending</td>
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<td>- Obligations to other international covenants, conventions (African Charter)</td>
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<table>
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<tr>
<th>Other Key Actors</th>
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<tr>
<td>International community</td>
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<tr>
<td>- International cooperation</td>
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<tr>
<td>- Resources, technical support</td>
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<tr>
<td>- Lobbying</td>
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<tr>
<td>Communities (local, religious, human rights associations)</td>
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<tr>
<td>NGOs and community-based associations</td>
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<tr>
<td>Parents</td>
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<tr>
<td>Women and children</td>
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Human rights concerns transcend community and national boundaries
OTHER FORMS OF SUPPORT FROM REGION TO HELP COUNTRIES ADAPT SITAN TO HUMAN RIGHTS APPROACH (1)

Production of Support Documentation

Producing support documentation is a critical first step to operationalising human rights-based programming to

- Explore meaning of human rights-based programming within the local context and to test the principles
- Learn through discussions and improve knowledge in programming within context of rights
- Open new roads into understanding the integration of the rights approach into programmes
- Provide targeted support to UNICEF staff to ensure main actors know and apply human rights principles

Key documents include

- CRC and CEDAW indicators for use in SITAN to monitor realisation of rights
- Training material on CRC and CEDAW, including complementarity between the two conventions and how to operationalise them
- Training material on CRC and CEDAW reporting
TECHNICAL SUPPORT AND TRAINING FOR COUNTRIES COMPLETING SITAN OFFERED AT KEY PHASES

Initial partner discussions

Identification of
- Existing data/studies
- Institutions/consultants

Technical support to complete assessment & analysis

Problem identification

Problem description
- Using quantitative & qualitative data
- At each stage of life cycle
- Without categorisation

Problem prioritisation

Focus in detail on underlying causes
- Immediate
- Underlying
- Structural

Identify key decision-makers & institutions

Resource analysis
- Human, org.
- Economic
- Natural

First draft completed, shared with regional draft shared with partners

Regional comments, analysis

Final draft published

Partner discussion distributed

Draft revision

Beginning of programme planning cycle based on SITAN
LESSONS LEARNED FROM COUNTRY SITANS
Feedback from Country Offices

Need for clear operational guidelines

• "Why can't the region give us a standard framework, like in previous exercises such as the nutrition framework?"

Need for a coherent approach from the regional office, particularly with regards to the use of human rights articles

• "Can't the region just give us an example of an analysis of the rights approach, with a clear use of the articles?"

Difficulty in operationalising intersectorality in the SITAN document

• "The ministries are sectorial, we are sectorial--how can we be expected to suddenly come up with an integrated document?"
LESSONS LEARNED FROM COUNTRY SITANS
Areas Needing Greater Emphasis

Increase focus on women and children as subjects analyzed within their environment (political, economic, social, cultural)
  • Not a legal document

Adopt more holistic, intersectoral approach
  • Even when programmes and institutions remain sectoral
  • Including vulnerability analysis and develop emergency preparedness plans as part of the SITAN

Use CEDAW and its complementarity to CRC in all cases where women and girls are subjects

Go beyond immediate manifestations to
  • Analyse underlying causes (vertical)
  • Show linkages between problems at various levels (horizontal)
  • Focus on resource analysis (human, organisational, financial)
LESSONS LEARNED FROM COUNTRY SITANS
Possible Approaches to Address Areas Needing Greater Emphasis

Foster greater staff appropriation during regional training events
- More active staff involvement
- Staff input/ownership of write-up
- Where consultant used, ensure active participation in all training and related discussions

Deepen involvement of region at all stages of the SITAN process
- Regular consultation and support as needed during assessment and analysis phase

Widen relationships beyond UNICEF traditional partners, e.g.:
- Human rights organisations
- Religious leaders
- Private sector

Where not already practiced, build intersectoral team to draft SITAN document

For UNICEF overall, send clearer and more consistent messages of strong support for CEDAW
- In communications, training manuals, guidelines, etc.
Objective: Demonstrate how the situation analysis methodology is equally effective and applicable to a variety of country settings
  - Including emergency and post-emergency countries

Approach:
1. Split into three groups to discuss applying SITAN to a human rights approach in
   - Emergency countries (example: DRC, Congo)
   - Post-emergency countries (examples: Liberia, Sierra Leone, Guinea-Bissau)
   - Other countries

2. Using provided outlines as a guide, draft a SITAN outline for the country selected by your group using a human rights approach (60 mins...)
   - Leave 15 minutes at the end of the exercise to discuss the difficulties encountered or anticipated in completing the SITAN

3. In plenary session, be prepared for one group member to present your outline and discuss the difficulties encountered (15 mins... each)

4. Agree on outline that addressed needs of all three types of countries (15 mins...)
ADAPTING SITAN TO HUMAN RIGHTS-BASED PROGRAMMING

Kate N. Lifanda
Regional Gender Advisor, WCAR

SPO meeting
Abidjan, February 14, 2000

Chapter 16 – Annex 1: Institutionalising Human Rights

Here is the original presentation:
INSTITUTIONALISING HUMAN RIGHTS APPROACHES IN POLICIES AND PROGRAMMES
Towards an Effective Framework for Women and Children

May 2000
K. LEFANBA - UNICEF/UNCRPD
**INSTITUTIONALISING HUMAN RIGHTS APPROACHES IN POLICIES AND PROGRAMMES**
Towards an Effective Framework for Women and Children

<table>
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<th>Session objectives:</th>
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<tr>
<td>1) Briefly lay out principles of human rights and the requirements they place on government agencies concerned with women and children</td>
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<tr>
<td>2) Identify concrete approaches that coordinating ministries can adopt to address human rights needs of women and children</td>
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<tr>
<td>3) Discuss the obstacles in implementation and how to overcome them</td>
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May 2000

K. LEFANDA - UNICEF/WCARO
THREE PRINCIPLES ARE COMMON TO ALL HUMAN RIGHTS CONVENTIONS

Universality/Non-discrimination

Interdependence

Indivisibility

These principles require a holistic and participatory approach to development
HUMAN RIGHTS PRINCIPLES REQUIRE A HOLISTIC AND PARTICIPATORY APPROACH TO DEVELOPMENT (1)

Universality/Non-discrimination

Non-discrimination on the basis of colour, race, gender, language, origin, opinion, disability

Special focus on most vulnerable groups (handicapped children, pygmies, urban and rural poor, slavery)

Attention to gender equality and equity between age groups

Requires extending focus to wide range of population groups
- With diverse, often severe socio-economic problems

To address these problems, results in need for
- Multiple actors
- Increased partnerships
- Substantially higher human, financial and organisational resources

Gender issues cut across government ministries, increasing need for coordination

May 2000

K. LEFANDA - UNICEF/WCARO
HUMAN RIGHTS PRINCIPLES REQUIRE A HOLISTIC AND PARTICIPATORY APPROACH TO DEVELOPMENT (2)

Interdependence

Indivisibility

Non-realisation of one right affects others

Women and children to be treated as subjects and actors analysed in their environments, not separately

Complementarity of rights between parents and children, girls and women

Requires coordination role for ministries leading women's and children issues
  • To advocate across technical ministries (health, education, etc.)
  • To influence decision-making on programmes and resource allocation
  • To help build a multi-sectoral team to address problems

Capacity needs to be build across all ministries to be familiar with rights issues
  • Especially at decision-making level
  • To ensure rights are integrated into all activities

Requires more participatory, decentralised approach involving women and children

May 2000

K.LIFANDA - UNICEF/WCARO
THREE KEY LEVERS FOR MINISTRIES TO RESPOND TO THESE NEEDS

- Structure
- Roles and responsibilities
- Financial and human resources
CREATING ENABLING STRUCTURES FOR INSTITUTIONALISING HUMAN RIGHTS IN POLICIES AND PROGRAMMES

Key Elements

Coordinating body/ministry for women and children's rights empowered at high levels

- Represented in key agencies, commissions
- Direct reporting lines to executive level

Focal points established for women's and children's rights

- At key decision-making levels in technical ministries and agencies (e.g. at director level)
- Decentralised to local government levels

Staff trained in promoting women's and children's rights across ministries

Working relationships explicitly formed with non-governmental and international organisations

May 2000

K. LIFANDA - UNICEF/UNFPA
ROLES AND RESPONSIBILITIES FOR INSTITUTIONALISING HUMAN RIGHTS IN POLICIES AND PROGRAMMES

Key Elements

Key role for coordinating ministry in influencing policy

- Within government structures
- Outside government

Need to form strong partnerships to reinforce

- Required services, resources
- Technical expertise
- Lobbying/advocacy
FINANCIAL AND HUMAN RESOURCES FOR INSTITUTIONALISING HUMAN RIGHTS
Key Elements

Need for rights-based budgeting to target the needs of the most vulnerable groups (gender, age, ethnicity, etc.)

Promote the 20/20 initiative for financing basic social services

Build capacity of ministry personnel to effectively implement rights-based approach to policies and programmes
  • Training
  • Create incentives to encourage successful implementation
DISCUSSION POINTS FOR INSTITUTIONALISING HUMAN RIGHTS IN POLICIES AND PROGRAMMES

How can the budgeting process be influenced to ensure children's and women's needs are identified and adequate resources allocated?

What are the obstacles to creating enabling structures for institutionalising human rights in policies and programmes?

How can a coordinating ministry influence policy within and outside government?

How can appropriate partners best be identified and attracted? What are some key pitfalls in structuring agreements?

What are the issues inherent to effectively training staff in a rights-based approach to policies and programmes?
Chapter 17: Managing Water Resources

Forenote

This chapter must be read in context with all pertinent annexes 1–5 and Chapter 19 and its annexes on sanitation. A quick reference to other key chapters on nutrition, health and shelter will help establish critical linkages. As well, for specific guidance related to water supply in cold climates, please refer to ‘Out in the cold: Emergency Water Supply and Sanitation for Cold Regions’ (see essential reading references at end of this chapter).

Rationale

Clean (safe) water for drinking and cooking and for personal/child/domestic hygiene is critical to preserving health and well being, especially of children and women, in emergency situations. The lack of a safe reliable water supply can cause great hardship and contribute to disease outbreaks, especially in densely crowded camp conditions typically found in emergencies where populations are displaced. Refer to Chapter 19 on sanitation for specific reference to disease risks. In some emergencies, a careful assessment of water for animals may be critical, especially if the affected population (pastoralists or other) largely depend on such animal stocks for their food or survival. In emergency situations, UNICEF (in close collaboration and coordination with other concerned organizations) will respond rapidly, within its mandate, to help meet emergency and longer-term water, as well as sanitation and hygiene needs of children. The extent and
intensity of this response will be contingent upon the availability of sufficient human, financial and supply resources. For specific guidance on UNICEF policy on WES for emergencies, please refer to paragraphs 54 – 60 of the Executive Board approved ‘UNICEF Strategies in Water and Environmental Sanitation’ (Document E/ICEF/1995/17, issued 13 April 1995). And for specific actions in emergency preparedness, particularly during the first 72 hours of the event, please refer to, and follow the UNICEF’s Core Corporate Commitments for WES. Annexes 1–5 contain additional information on water: distribution and storage; water sources; quality and treatment; pumps, pipes and fittings, and WES in urban areas.

General Aim

To prevent disease risks to children and women by assuring rapid response in providing safe water supply (and sanitation/ hygiene services) for drinking and cooking and maintaining good personal-, child- and domestic- hygiene.

Other key supporting interventions needed are:

- Identification and targeting of most vulnerable groups to assess/analyse the water related disease and shortage risks they face and to determine key strategies to employ;
- Joint planning, where possible, with concerned partners for immediate critical interventions,
- Effective coordination;
- Linking of initial planning, implementation and policy decisions to longer–term development;
- Strategic linkages to sanitation, nutrition, health, shelter and education;
- Participation of target populations in decision making and actions; and,
- Periodic monitoring and analysis for further action.

Basic Principles

- Water is a basic human right and essential to sustaining life.
- Integrated assessment, planning and coordinated implementation to maximize synergies with key sectors such as sanitation, nutrition, health, shelter and education.
- Adaptive programming to response rapidly to changing needs and priorities over the course of the emergency.
- Cost–effective options (including technologies) be considered, for example give priority to essential repairs rather than full rehabilitation, or protecting of dug–wells rather than drilling of new boreholes.
- Health and hygiene education be promoted to prevent water–related diseases, lack of water and sanitation.
- Test and periodically monitor all water supplies (for drinking and cooking) to ensure safety for human consumption (chemical and bacteriological analysis) and take preventative and/or corrective action where necessary.
- Water conservation measures be initiated and promoted from start of emergency.
- Periodic/continuous monitoring and surveillance to facilitate informed decision making and adaptive programming.
- Appropriate technologies and interventions to address the prevailing socio–cultural and gender needs and the local ecology.
• Local capacity building, including other critical levels (sub-national/national), to deliver and sustain water supply services.

• Participatory approaches to meet objectives, empower affected populations and promote their role in planning, implementing, managing and monitoring of services and activities.

• Strategic partnerships are developed to ensure holistic planning, complementarity, coordination and cooperation with government, partner UN agencies, NGO’s and others.

• Emergency planning and implementation to link to long-term development.

**Identifying Priorities**

• A child-focused needs assessment is paramount at the beginning of an emergency to ascertain their critical water (and sanitation and hygiene) requirements. But also to identify potential supporting factors within their families, local community and water supply services regarding skills and knowledge and other essential resources for providing and sustaining of services for the duration of the emergency. If regional differences exist, a single assessment may obscure critical geographic differences. A separate assessment for each affected area may be necessary and, if no reliable data exists, the use of limited sampling methodologies can provide key information quickly. See section ‘establishing a baseline’.

• Sources of information include local community and religious leaders, water sector specialists, health inspectorate/ministry, local NGO’s and other concerned institutions and agencies.

• Assessments should be done jointly, where possible, with other concerned organizations and should ensure linkages to other critical sector assessments such as sanitation, nutrition, health and shelter.

**Establishing a Baseline**

A baseline database should be established to facilitate strategic and appropriate decision-making regarding emergency priorities, strategies and to measure medium- to longer-term trends. This should be done, where possible, together with key stakeholders in the local community such as traditional and religious leaders, government extension workers in sanitation, health, the environment and their parent ministries, other concerned organizations and local institutions involved in sanitation and hygiene:

• Critical documentary information and analysis on water specific problems (technical, institutional, policies and capacities) to the sustaining of such services and activities.

• Assessment/analysis of knowledge, attitudes, practices and skills regarding water use and management, as well as keeping it safe from source to mouth;

• Assessment/analysis regarding the transmission routes and control measures of pertinent water borne diseases, as well as how these affect nutrition and health.

• Information on motivating factors regarding water source maintenance and resources management;

• Demographics of the affected area/s;

• Literacy level/s;

• Pertinent gender and cultural issues and roles;

• Information on pre-emergency self-help (or other) regarding water infrastructure and coping skills;
• Review of water point inventories and their status;

Assessment of the required technical resources, as well as local availability of expertise, to fully address water supply in the emergency.

**Strategies**

• To extend water services, as soon as possible, to affected families/communities for drinking, hygiene and cooking – and where critical, livestock and other essential food production needs;

• To restore/extend previously existing (drinking and domestic) water sources/systems;

• To develop alternative arrangements for water supply where necessary;

• To improve access to water, and thereby free up time and energy for other essential family survival and development activities;

• To promote water conservation wherever supplies are limited, and to protect the environment;

• To promote partnerships and coordination for emergency water supply.

• To promote interventions that link emergency action to long-term sustainable development programmes.

**Role of UNICEF**

Following assessment/s, it may be useful to ask if water, or the lack of it, is affecting the survival and development of children, or is it anticipated to? Does UNICEF:

• Have the technical, supply and organizational capability in-country to deal with the problem?

• Have the resources and ability to quickly mobilize capability from external sources?

• Have the financial resources on hand or can it mobilize these quickly?

Could UNICEF:

• Provide effective support through its normal country programme by increasing assistance to government, NGOs, local institutions and other partners?

**Field-Level Actions and Strategies**

The following are some typical water-related problems encountered in emergencies, with actions to consider.

**Camp-Based Populations – Refugee/Displaced**

**Problem:**

A sufficient amount of surface or close-to-surface water exists (lake, river, stream, dam, unprotected spring or well) but it may require one or more of the following: pumping, treatment, storage facilities, and distribution system.
Actions to consider:

Plan, organize and implement where needed:

- Surface pumping facilities
- Water treatment system
- Storage facilities
- Distribution systems
- Ensure that families have sufficient water collection and storage containers
- Ensure that critical capacity building is done at local level for sustaining water services
- Ensure that appropriate hygiene education is given
- Ensure, as a priority in all cases, that regular water quality testing and monitoring be done, particularly where there is risk of water borne diseases contamination and/or water contamination by chemicals and natural geological conditions.

Problem:

Only limited surface and close-to-surface water exists but there is potential to supplement it by digging or drilling shallow wells (not more than 30 metres deep).

Actions to consider:

- Plan and organize team/s to construct the wells by manual means.
- Explore potential to quickly mobilize drilling teams and equipment.

Problem:

Both surface and close-to-surface water are very limited, but there is potential to drill deep boreholes.

Actions to consider:

- Plan, mobilize teams and equipment and organize drilling operations.
- Plan for pumping, storage, distribution and treatment system, if needed.

Problem:

There is insufficient water supply from all potential local sources combined (including rainwater harvesting).

Actions to consider:

- Relocate camp population to more appropriate site.
- If above is not possible, truck water to camp, only as a very temporary solution.
- Plan and develop a more appropriate water supply such as a piped system from the nearest suitable source. Potential may exist to gravitate the water to site.
- Explore possibility of upgrading the capacity of the water systems used by the local permanent population and use the surplus water for affected population. It may be advisable to ensure that the permanent local population gets improved water supply (in quantity and level of service) as a result of this. This also helps to alleviate tension between displaced populations and local host communities.
- Explore rainwater harvesting.
- Explore potential for small-scale dams on seasonal or perennial rivers or streams.
Rural-Based Populations – Non-Displaced

Problem:
Lack of adequate amount of water due to lowering of watertable(s) resulting from prolonged drought. This would include drying up or serious reductions in available quantity of water from boreholes, shallow wells, springs, lakes, rivers, streams and dams.

Actions to Consider

- Immediately establish and enforce strict criteria for water conservation in order to preserve human life and essential food reserves and production.
- Deepen existing wells and boreholes, hydro fracture if appropriate.
- Construct subsurface or surface dams in rivers and streams to retain as much water as possible.
- Explore new underground water reserves through hydrological surveys and quickly develop these.
- Treat (to prevent outbreak of diarrhoeal diseases) all water from unprotected sources especially ponds, water-holes etc., that are closer to users than protected sources – should there be risk that these may be used.

Problem:
Lack of adequate safe water due to breakdown or damage of existing system(s), i.e. boreholes with pumps, protected springs and shallow wells, and other sources such as piped systems.

Actions to consider

- Plan and implement repair.
- Disinfect and manage existing water systems.
- Assess risks of mines and other explosive devices and determine safety measures to be taken.
- Explore the development of other more locally sustainable and cost-effective systems such as improving/protecting natural springs or traditional wells or harvesting rain. This may be important if poor security prevents the access to existing systems or if power supply, fuel or spare parts are not easily available or affordable to repair or sustain them.

Problem:
Drinking water supply is contaminated as result of pollution from latrines, septic systems, agricultural or farm animal waste, or flooding.

Actions to consider:

- Immediately inform the affected population:
  - of the risks involved, and if they should not use the water (if contaminated by chemicals);
  - on how to disinfect or boil their water (if bacteriological contaminated) to make it safe for human consumption and use;
  - on how to safely store and use water in the home;
  - on what precautions are needed to maintain their health under the prevailing circumstances;
• on what steps need to be taken to rectify the problem by themselves or by the authorities responsible for water.

• With the involvement of the affected population:

• immediately trace the source(s) of the contamination and take steps to quickly rectify the problem;

• immediately disinfect (clean out if necessary) all water supply systems/ sources (wells, boreholes, springs, or whatever source the population draws its water from);

• establish a system to regularly monitor water quality and the steps to be taken if contamination is found.

Urban-Based Populations

Problem:

Lack of adequate amount of safe water from piped water systems due to a sudden increased demand on a limited supply as result of a large population influx (see annex 5).

Actions to consider:

• Explore potential to increase pumping capacity, storage and treatment and expand piped network if needed.

• Explore potential to develop and protect hand-dug or drilled wells or to gravitate/pump water from other sources.

• Explore potential to deliver water by local vendors (could be costly, monitor water quality).

• Carefully check and maintain water quality.

• Explore truck deliveries (not very sustainable).

• Treat all water from unprotected sources.

Problem:

There is a lack of adequate amounts of water due to breakdowns or damage to systems as result of armed conflict or neglect.

Actions to consider:

• Plan and implement emergency rehabilitation and/or repairs and disinfect and manage existing water systems.

• Assess the risks of mines and other explosive devices and determine safety measures need to be taken.

• Immediately enforce strict water management to ensure that everyone gets a basic minimum, for example: cut off supply to areas where large leakages exist until these are repaired, establish water collection standpipes on streets and manage these until individual households repair their leaking taps and pipes.

• Charge, where feasible, an affordable price for water to instill a sense of value on it.

• Repair sewage leakages to prevent contamination of drinking water supplies.
• Ensure good drainage of storm and wastewater to prevent contamination of drinking water supplies.

• Explore more sustainable and cost-effective options.

Problem:
Contamination of water supplies resulting in high-risk or outbreak of serious health and life-threatening diseases caused by flooding, or sewage or other bacteriological/pathogenic or chemical pollutants entering the water system.

Actions to consider:
• Immediately inform the affected population:
  • of the risks involved, and if they should not use the water (if contaminated by chemicals);
  • on how to disinfect or boil their water (if bacteriological contaminated) to make it safe for human consumption and use;
  • on how to safely store and use water in the home;
  • on what precautions are needed to maintain their health under the prevailing circumstances;
  • on what steps need to be taken to rectify the problem by themselves or by the authorities responsible for water.

• With the involvement of the affected population:
  • immediately increase disinfection levels in the water supply to ensure that there is enough residual disinfectant to maintain safe water standards at the point of consumption;
  • immediately trace the source(s) of contamination, rectify/repair it and disinfect the system;
  • establish a system to regularly monitor water quality and the steps to be taken if contamination is identified;
  • endeavour to keep the water supply network under constant pressure (24 hours a day) to prevent contaminants leaking into the system. If this is not possible, increase the disinfection levels in the water until all repairs are made and the risk of disease is over.

Assessing Water Needs
Actual water needs depend on several factors and may vary greatly from one situation to the next. These include:

• temperature
• human workloads
• hygiene and environmental conditions
• exposure to water– and sanitation–related diseases
• essential economic activities related to water availability and use, especially for stock animals and household food security
• standards prior to the emergency
• the type of technologies used
• costs and affordability

For example, conventional flush toilets would require more water than a pour−flush toilet or dry−pit latrine. A population used to having plenty of available water piped into the home may find it difficult to cope with very limited amounts, whereas, this may not be so difficult for those not having such a high level of service prior to the emergency. A general indication for estimating water requirements in emergencies is given in annex 1 on detailed water assessment checklists.

Assessment Guidelines

An in−depth assessment of the water sector should provide emergency planners with essential information on issues related to:

• current amounts of water available to families or target population and essential health and community services;

• basic facts on family access to water sources/systems, their working condition, capacity, water quality, and time spent collecting water;

• key problems and facts on water−borne or −related diseases affecting the target population;

• estimates of how much water is required and how it is to be provided;

• populations, age groups, institutions with special water needs or that are at particular risk;

• institutional arrangements and sector policies for water;

• what resources are available, still needed and when they are needed;

• identification of essential and immediate actions to be taken and by whom.

In addition to the general methodological guidance provided in Book One, chapter 10, it is important to identify and use professionals from the affected population in assessment activities. It is common to find engineers, technicians, health workers, communications people, artisans, etc., especially among refugees and displaced populations.

Analysis of Assessment

• The following are key questions to be used to summarize or analyse assessment of water needs.

• What are the immediate priority water needs?

• What immediate actions are needed to control water−related diseases?

• What are the medium−term programme needs?

• What are the special needs of children and women?

• What key actions are needed to plan and implement the emergency water programme?

• Which agency will have the lead role of coordinating the emergency?

• What role will UNICEF play?

• What role will other agencies, NGOs etc., play?

• What partnerships can be established?
• What are the resources requirements and when are these needed?
  
  • financial
  • human
  • equipment, spare parts and other supplies
  • vehicles
  • tools
  • training

• How will the programme be monitored and evaluated?

• What would be the implications if limited or no action is taken?

**Assessment**

It is imperative to fully assess the water situation 'on the ground' in order to determine:

• the scale of the problem;
• its future implication if not quickly addressed;
• the critical survival and health needs of the affected population;
• what immediate and longer-term actions can be taken?

**Further Guidance (Essential References)**


Lloyd B. and Helmer R. (1991), Drinking Water Quality in Rural Areas (Longman Scientific and Technical)

Benson A. S. (1990), Control of Communicable Diseases in Man (American Public Health Association)


House, Sarah, and Bob Reed, Emergency Water Sources: Guidelines for selection and treatment, WEDC, 1997


Also refer to the more extended list of references at end of Chapter 19 (Sanitation).
Chapter 17 – Annex 1: Distribution and Storage of Water

Objective

To conserve and protect available safe water supplies, and make available within reasonable distance to affected population and host community.

Priorities

- Restore/provide supplies to and within hospitals, other health facilities and premises being used for special child-care, health/nutrition and feeding programmes have the highest priority.

- Access to other available supplies must be shared as equitably as possible between all community groups and households.

Special attention to the distribution and storage of water is necessary whenever:

- Existing piped distribution systems have been damaged and/or contaminated;

- Traditional sources are no longer usable and supplies are available only at some distance from the affected population;

- Displaced persons are concentrated in small areas.

Action is then required to:

- Inventory available sources of supply, storage and distribution capacities – their location, quantity and quality (and to estimate requirements in each area)

- Minimize risks of waste contamination of available water supplies;

- Make at least minimum quantities of safe water accessible to people where they live/shelter;

- Warn people of the dangers of using particular sources and supplies known to be unsafe.

Wherever water supplies cannot be assumed to be safe, immediate action to provide adequate capacity to store water and therefore improve its quality – at distribution points and/or in households/camps – is a logical first step.

If large numbers of people have to be served from a small number of sources:

- Feed/deliver water into storage tanks/distribution;

- Provide appropriate means for users to draw-off water – probably through rows of taps;

- Organise distribution to facilitate equitable access to water supplies and to avoid conflict during collection.

The larger the numbers of people using a single source or outlet, the greater the risk of pollution, damage and conflict. Panel 1 provides guidelines for setting up temporary storage and distribution points.

Consider delivering water by truck only as a very short-term, temporary measure.

Wastewater

To reduce health hazards and maximize benefit in situations where supplies are limited, repair/construct channels or pipes to drain waste water away from distribution points, households and communal services to
soakage pits or tanks (or lined pits). This wastewater should be recycled where possible e.g. for livestock, irrigating crops/vegetable gardens (if not soapy) or use in flush latrines.

**Municipal (piped) Systems**

Municipal piped water supply systems can be complicated. Operating such a system requires trained and experienced engineers and/or technicians.

Where an existing municipality has been or may be severely damaged in an emergency, it is often helpful to consider a phased response:

- Preparedness
- Emergency interventions
- Restoration of piped water to street level
- Full rehabilitation and improvement

The following notes consider each of these phases in turn:

**Preparedness**

In an emergency, the best operators will usually be those who normally operate the system. Establishing and maintaining contact with the municipal technicians is a very important pre–emergency preparedness measure. It is also helpful to maintain a file/plans on system layout and specifications; local geology; hydrology and unusual weather events that may assist decisions regarding adapting and/or alternative water sources. Information may also be available with partner agencies (World Bank, European Union). Get data from such agencies if it seems that they may discontinue programmes.

**Emergency Interventions**

This phase is characterized by the need for rapid action to minimize disease risks and save lives. If piped systems have been damaged ensure rapid action to:

- Isolate the damaged sections to minimize losses and maintain system pressure, thus preventing pollution seeping into the system;
- Provide sufficient supplies for all communities through standpipes wherever possible;
- In localities where a piped system has been totally disrupted, locate temporary storage and distribution tap–bars, and deliver necessary minimum/survival supplies by truck for a few days until sufficient stand pipes can be restored/established;
- Rehabilitate other sources (private, disused mosque wells, etc.) if available and disinfect, pump, store, and locally distribute;
- Make whatever immediate/temporary repairs are possible with the materials and expertise on hand;
- Organize detailed surveys to prepare plans and estimates for complete rehabilitation and/or develop more appropriate, under the circumstances, water sources.

Remember that communities on high ground will always get less water than those lower down, especially if pumping in the system is intermittent.

If the system has been contaminated, and also after any repairs (temporary or permanent) have been made, ensure disinfection of the sections concerned by:
• Increasing the pressure in the system as a whole, if possible;
• Increasing the residual chlorine content in the water, assuming a chlorination treatment facility exists (if not, hand dose it).

In all cases, ensure the availability and the effective organization of necessary equipment and personnel (including a functioning public health laboratory) to:

• Monitor water quality at delivery points and ensure the public is immediately informed of contaminated supplies and advise them on what they can do to minimize disease risk;
• Respond quickly when any breakdowns, leaks or contamination are discovered.

Restoration

The target of this phase will be to restore functions of the municipal system such that private consumers have access (defined as one outlet per street or within 200 m, whichever is closer). Quality of water will be standardized according to the norms of the original supply or to current WHO standards adapted to the situation.

Reduction of leaks will raise pressures, reduce possibility of contamination and improve supplies in higher districts.

Identify previous consultants, contractors, past colonial administrations and donor organizations that may have contributed to constructing the system. Apply to them for information.

Action must be taken to maintain power (electrical or other) supplies and standards (e.g. voltage and phase) to ensure continuous water system pressure and prevent electrical hardware damage.

Modify the system, if necessary, to prevent repetitive damage to components from deteriorating operating conditions. (e.g. voltage/phase protection; strainers before pumps, etc.)

Opportunities may arise for regenerating local economic activity.

Inputs in this phase must be planned carefully to avoid compromising options for later full rehabilitation.

In general, investment of resources on the scale needed in this phase requires political stability to enable the necessary institution capacity building. Consider options carefully if the emergency conditions persist (e.g. conflict continues).

Rehabilitation and Improvement

At the end of this phase, full services will be restored to all consumers, including agriculture, industry, district heating systems and incoming populations. Upgrading (water and effluent treatment) and extension (peri−urban areas) of the system may be appropriate.

This phase will involve major civil engineering design and (re) construction and may occupy a time frame of years, possibly more than a decade.

Locations Lacking Infrastructure

If previous sources are usable or able to be rehabilitated quickly and demands have not increased, restore pre−existing arrangements for distribution. During the emergency phase, changes/improvements should only be attempted if the necessary materials and manpower are readily available and the restoration of supplies – of a quality not worse than that to which the population was previously accustomed – will not be further delayed.

New arrangements for distribution and storage may be necessary when output from existing sources has to be substantially increased and/or new sources be developed (see annex 2) because:
• Some previously used sources are no longer available or not yielding sufficient water; or
• An enlarged population has to be served.

If the water quality is good at source but needs to be brought closer to the population: deliver it through watertight pipes into storage tanks at suitable distribution points, if possible. Panel 2 provides some guidelines concerning pipes.

If water is of poor quality or moved in open channels, store, filter and/or chemically treat it at the distribution point to make it safe for domestic use.

In areas liable to flooding during the rainy season, or where the source is a river of which the level may vary markedly during the expected period of use, ensure that all pumps, storage and treatment systems are located above the highest water level that might be anticipated.

Consider deliveries by truck only as a last resort and only for as long as it takes to pipe water in, develop other sources or move the population.

A typical water tanker of capacity 8,000 litres carries sufficient water to meet the normal minimum requirements (15 l/day/person) of only 530 people for just one day, or the survival requirements for drinking alone (3 l/day/person) of 2,700 people for one day. Attempts to truck in water for large numbers of people are likely to be extremely expensive or impracticable.

Delivering Water by Truck

Where there is no alternative to temporary truck deliveries:

• Mobilize suitable tankers;
• Establish temporary storage/distribution tanks at strategic locations;
• Chlorinate water in the tankers;
• Schedule deliveries according to carefully determined priorities.

Water tankers may be available with the military, fire services, dairies or bottled−drink factories including breweries. It is difficult to adequately clean petrol and oil tankers. If suitable tanker trucks cannot be found, place steel or collapsible tanks on ordinary trucks. Secure them firmly: For collapsible tanks use strong webbing or nets (1 cubic metre [1,000 litres] of water weighs 1 metric ton).

Static tanks should be set up at the selected distribution points so that trucks do not have to wait while individuals collect their needs/rations (see Panel 1).

Trucks must carry pumps to deliver water into the static tanks (unless the trucks can deliver from a higher level than the tanks so that gravity feed is possible).

After community services, priority must be given to delivering supplies to public distribution points. No deliveries to private/domestic tanks should be permitted until the demand for water at public distribution points is fully satisfied.

People with their own transport should be encouraged to collect water from the more distant sources so that quantities delivered to local distribution points remain for the less privileged members of the community.

Water for such operations may be drawn from: usual municipal sources if still usable and quantities are sufficient, tubewells belonging to industrial establishments or other institutions, surface water as a last resort while other sources are being developed.

Providing for Institutions

Ensure adequate, safe supplies from:
• Any existing municipal system;
• The institution’s own well/water source, pre-existing or newly constructed; and/or
• The pumping and careful treatment of river water.

Deliveries by truck may be necessary on an emergency basis while other arrangements are made.

Prioritising within institutions may be necessary. For example the order of priorities in an emergency hospital may be:

• Operating theatres and intensive-care units).
• Kitchen and laundry.
• Wards (possibly rationed if open to public).

Assistance may be necessary for fire brigades in pumping and storing water if the hydrant system is not working. Water quality is irrelevant for short periods (e.g. sea water).

Possible UNICEF Inputs

Depending on the assessment of actual needs and possibilities, some of the following inputs might be considered:

• Expertise to help to plan and implement appropriate arrangements (sanitarians and practical water supply engineers).
• Spare parts and other materials for emergency repairs to piped water distribution systems serving hospitals, other health facilities and special feeding centres.
• Water tanks, pumps, pipes, pipefittings, solvents for plastic pipe joints, pipe cutting and other tools, etc., to establish emergency storage and distribution arrangements for communities.
• Funds for the operations of trucks for emergency deliveries to community services and particularly needy communities (where there is no immediate alternative).
• Supplies and other support for water testing and treatment operations.

Further Guidance

Aqua Plus, UNICEF


Manufacturers’ catalogues (available from Supply Division: see catalogue)


*Water and Sanitation in Emergencies*, A. Chalinder, Overseas Development Institute, 1994

*Water Manual for Refugee Situations*, UNHCR, 1992
Panel 1 – Temporary water storage and distribution points

<table>
<thead>
<tr>
<th>Temporary water storage and distribution points</th>
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</thead>
<tbody>
<tr>
<td>The storage capacity required at each distribution point depends on the number of people to be served and the frequency of deliveries. Assuming 20 litres/person/day, 1,000 litres provides for 50 people if filled once a day, 100 people if filled twice daily, etc.</td>
</tr>
</tbody>
</table>

In the initial stage of a complex emergency it may be necessary to ration water to 7 litres per person per day. This amount should be upgraded as soon as possible.

3–4,000 litres (3–4 cubic metres) galvanized steel tanks are often suitable and available locally and/or planned for, if already known, that an emergency was unfolding. Otherwise it may be necessary to obtain collapsible rubber/PVC tanks (by flying them in if absolutely necessary).

Tanks should be mounted on raised platforms or mounds so that water can be drawn off from the bottom. Collapsible tanks must be on level surfaces free of glass or sharp stones and surrounded by a barrier to prevent rolling.

Users’ containers must never be dipped into tanks. Tanks should be covered and taps be installed either directly in the tank or on pipes leading from it. There should, if possible, be one tap for every 200–250 users, and an ample stock of replacement taps. As a last resort only, a single, clean ‘captive’ container may be provided to be dipped into a tank (as for an open well).

Screw-type and push taps are frequently broken or jammed. Self–closing valve taps have proved reliable: those made in India are inexpensive – $3.40 excluding freight in 1985. Ask Supply Division for details, delivery possibilities and current prices.

Collapsible tanks are available from Supply Division – 5,000 litres Supply Division 56– 750–0Q 1,500 litres Supply Division 56–750–01. They can sometimes be obtained as donations in–kind from governments. OXFAM can supply ‘easy–to–assemble’ tanks complete with distribution systems. Ask EOU and Supply Division for further advice.

To disinfect a tank:

1. Half fill the tank with water;
2. Pour in 1 litre of 1 percentage chlorine solution for every 100 litres of tank capacity;
3. Fill the tank up with water;
4. Leave for 12 hours; 5. Drain off water and recycle, where possible, or discard it.

Panel 2 – Pipes for Small–Scale Distribution System

<table>
<thead>
<tr>
<th>PIPES FOR SMALL–SCALE DISTRIBUTION SYSTEM</th>
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<tbody>
<tr>
<td>Flow rate</td>
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<tr>
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</tbody>
</table>

Bamboo may be able to be used for short–term/temporary installations. Otherwise plastic pipes are usually the cheapest, light to transport and easiest to lay. They are available in lengths of coiled, flexible pipe up to a diameter of 100mm, or in rigid lengths.
The diameter of pipes needed depends on the required flow rates, the length of the pipeline, any rise and fall on the route, and whether gravity−fed or pumped. Experts should calculate it. The figures below, extracted from ref. a, provide only a general indication for a gravity−fed system:

<table>
<thead>
<tr>
<th>(Litre/sec)</th>
<th>Flat</th>
<th>Steep</th>
<th>Flat</th>
<th>Steep</th>
<th>Flat</th>
<th>Steep</th>
</tr>
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<tbody>
<tr>
<td>0.10</td>
<td>32</td>
<td>19</td>
<td>25</td>
<td>19</td>
<td>19</td>
<td>12</td>
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<tr>
<td>0.20</td>
<td>37</td>
<td>19</td>
<td>32</td>
<td>25</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>0.40</td>
<td>50</td>
<td>25</td>
<td>37</td>
<td>32</td>
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<tr>
<td>0.50</td>
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<td>32</td>
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<td>32</td>
<td>32</td>
<td>25</td>
</tr>
<tr>
<td>0.80</td>
<td>62</td>
<td>32</td>
<td>50</td>
<td>37</td>
<td>37</td>
<td>32</td>
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<td>1.00</td>
<td>62</td>
<td>37</td>
<td>62</td>
<td>50</td>
<td>37</td>
<td>32</td>
</tr>
<tr>
<td>2.00</td>
<td>50</td>
<td>76</td>
<td>62</td>
<td>50</td>
<td>37</td>
<td>32</td>
</tr>
<tr>
<td>3.00</td>
<td>50</td>
<td>76</td>
<td>62</td>
<td>62</td>
<td>50</td>
<td></td>
</tr>
</tbody>
</table>

'Flat' = pipes sloping at less than 1:15(7 O/o) but more than 1:50(2 %).

'Steep' = pipes sloping at more than 1:15(7) but less than 1:5(20%~1

If the system is expected to be used for an extended period, pipes should be buried for protection, and sections of the system should have isolating valves. If pipes cannot be buried, galvanized iron pipes must be used.

Joints must be watertight. If there are leaks, pollution will be sucked in when pressure drops or the system is turned off.

See p. 339 and Guide list OLGA for further details.

Chapter 17 – Annex 2: Water Sources (Exploitation and Rehabilitation)

Objectives

To ensure the availability on a continuous basis of (a) sufficient safe water for hygiene and domestic use and (b) adequate water for livestock and community−level food production.

This includes the operation and maintenance of the systems installed to raise/deliver the water, as well as the development of sources themselves.

Note: Insufficient water can be more detrimental to health than large quantities of slightly contaminated water. Apart from potentially fatal dehydration when daily intake is insufficient to replace moisture lost from the body, parasitic, fungal and other skin diseases, eye infections and diarrhoeal diseases all increase when bodies, clothes and cooking utensils cannot be properly cleaned, and food can not be adequately prepared.
Choosing Sources

Panel 1 lists possible sources and some of the main considerations regarding their use:

- Rain and groundwater from natural springs or deep wells – when adequately protected – is usually microbiologically safe.
- Surface water is unlikely to be safe: water in ponds and lakes (i.e. not flowing) is often grossly polluted.

Shallow wells often deliver filtered surface water; sometimes they tap groundwater sources.

Rehabilitate and increase the yield of previously established sources, if possible, before seeking new ones. Remove any sources of pollution (especially latrines) that may be within 30 m.

If new sources are necessary:

- Thorough surveys and/or reliable existing data are essential before resources (time and funds) are committed to digging or drilling for groundwater.
- If new sources are needed and groundwater is known to be available, the choice of method of exploiting it depends on the depth of the water table, yield, soil conditions and the availability of expertise and equipment.
- If new wells are to be sunk, they should be at least 30 m away – preferably uphill – from any sanitation facilities or other obvious sources of possible pollution. (Very deep borewells may be accepted.)

Panel 2 lists the aspects to consider in choosing between alternative sources and means of exploitation. Panel 3 suggests the main criteria involved in determining how available sources may be exploited.

Seawater can be used for almost everything but drinking and irrigation, thus reducing fresh water requirements. Desalination is not a feasible means of providing fresh water in an emergency. If there are no fresh water sources, the population may have to be moved.

Rainwater

If other sources of safe water are limited, organize the collection of as much rainwater as possible (see Panel 4). Reasonably pure rainwater can be collected if:

- The roofs of buildings (not thatch) or tents are clean and guttering in place; and
- Appropriate collection and storage containers (e.g. plastic, glass or earthenware pots, but preferably not metal) are available to households and institutions.

Allow the first rain after a long dry spell to run off, thus cleaning the catchment of loose dirt.

In some situations, it may be possible to collect and store rainwater that runs off hard ground during heavy storms:

- Dig pits (or build small dams) in suitable locations and line them with polythene.
- Keep them covered, if possible, when not directly receiving rain.

Rainwater can be a major source only in areas and during periods when there is adequate and reliable rainfall, but it can be:

- A useful source of safe water, for both household and institutional use, during the rainy season when surface water is particularly likely to be contaminated (i.e. at a time when other water is plentiful but unsafe).
A useful supplement to general needs at any time, e.g. through special collection for community services such as health and feeding centres, where the safety of water is most important.

Natural Springs

Spring water is usually pure at the source and can be piped – often by gravity feed – to storage and distribution points. The locations of springs are normally known to the local population: They are typically indicated by a concentration of vegetation greener than most of the surroundings.

Protecting and Exploiting Springs

Check the true source: Some apparent springs may really be surface water that has seeped or flowed into the ground a short distance away.

Draw water off at the source itself, if possible. Otherwise, prevent any human activity or animal grazing between the source and the take–off point.

Protect the source against pollution:

• Construct a simple ‘box’ of bricks, stones or concrete dug into the ground which encloses and covers the source, and from which the water flows directly through a pipe to a tank or collection point nearby (see Panel 5).

• Fence off the source wherever possible and place the delivery point outside the fence.

Disinfect any source that has been polluted and any ‘box’ that has been repaired or constructed:

• Scrub the box with 2–3 bucketfuls of a strong chlorine solution (see Panel 12).
• Then, let it flow until the residual chlorine level drops and the water is acceptable to taste.

Estimating Yield of a Spring Source

If water is delivered from the source through a pipe, simply use a watch to determine how long it takes to fill a calibrated container (e.g. a 1 litre jug or 10 litre bucket).

Note: The yield may vary widely with the seasons. It will be at its minimum at the end of the dry season. The yield potential of a well depends on the geological formation in which it is sunk, the contours and gradients of the land, and the well construction. Actual output up to that maximum depends on the pump. If wells are sited too close together, yields will be reduced.

Tube Wells (boreholes)

Methods for sinking or drilling tube wells depend on the depth of the water table and the soil conditions above it (see Panels 3 and 6).

In all cases, a concrete apron at least 2 metres in diameter and sloping down towards the outside all round is necessary to prevent any waste or other surface water seeping into and contaminating the well. See Panel 7. A gutter (shallow trench) should drain wastewater away to a gravel/stone–filled soakage pit, or animal trough.

Equipment and Materials Required

The construction of tube wells requires:

• Drilling equipment appropriate to the soil conditions, depth of water table, and technical expertise available;
• Pipes and well screens of appropriate sizes;

• Pumps (see annex 4); and

• Construction materials i.e. adequate quantities of cement, sand, gravel, bricks/stones, reinforcing rods, shuttering, etc., to make the wellhead.

Pipes are normally of steel (with threaded joints between sections) or PVC (with either threaded or glued joints). Bamboo may be able to be used, on a temporary basis, in some situations.

Well screens are commonly made of brass or PVC, but improvisation with bamboo may be possible – plug the bottom and cut many narrow slots into the sides.

Any new tube well or borehole must first be ‘developed’ to full yield by an initial period of pumping at a fast rate. This has the effect of pumping out finer soil particles, thus allowing water to pass more easily into the well.

If the site is liable to flooding in the rainy season, design the installation accordingly, e.g. provide a raised platform or a flexible connection from a raft to a sealed well head using a submersible electric pump.

Rehabilitation of Tube Wells

Tube wells may be damaged/polluted by: physical damage to the well head and pumping installation and/or contamination by polluted water entering through a damaged well head or an inadequate apron. They may also dry up, partially or completely, if groundwater conditions change.

For the repair/replacement of pumps, ensure sufficient, appropriate spare parts, tools, transport and mechanics.

If the tube well itself has been damaged or blocked with debris:

• It is sometimes possible to withdraw the pipe and screen and install replacements in the same hole: an appropriate hoist is needed as well as replacement pipes, joints and screens, and materials to reconstruct the apron.

• Frequently, however, a new well will have to be sunk nearby, or an alternative source be found.

If water has become contaminated:

• This can sometimes be cleared by rapid pumping over an extended period and washing out the pump itself with a strong chlorine solution (see Panel 12).

• Alternatively, 3 buckets of strong chlorine solution may be poured into the well tube, left for some hours and then pumped out.

• Repair/replace the concrete apron around the wellhead and improve the drainage to a soakage pit as necessary.

• Thoroughly wash out and disinfect any storage and distribution system connected to the well.

Test the water to see if the pumping/disinfection has succeeded. If not, try to determine and remove the cause of the pollution.

Deepening/Enlargement of Tube-Wells

If the yield from a well has fallen, try to redevelop the well by fast pumping. If this fails – or if contamination has not been cleared by other efforts – try to deepen the well. If the existing pipes can be withdrawn, the same hole may be deepened by whatever means/equipment is available and appropriate to the soil conditions. Otherwise, construct a new well nearby.
If more water is needed than is presently able to be pumped, and if test pumping shows greater yield to be possible, withdraw the existing pipes, if possible, then re-bore, sink a larger diameter pipe and install a larger capacity pump or additional handpumps.

Wells should be lined – with stone, bricks or reinforced concrete – for at least the first 3 m below ground level to prevent surface water entering the well and to prevent the sides caving in. In sand/gravel soils the lining should extend to 6 m depth.

Various mechanical devices may raise water, but most commonly it is hand-drawn using buckets or similar containers on the end of a rope. Panel 9 and Panel 10 suggest measures to minimize risks of pollution.

If large numbers of people need to use a single well, it is best to cover it and install a pump (see Panel 11).

The final deepening of any dug well should take place at the end of the dry season when the water table is at its lowest level. A 20 cm layer of coarse sand/gravel placed at the bottom of a well helps to filter out sediment.

**Rehabilitation of dug wells**

Open dug wells may be damaged/polluted by: collapse of the lining and/or headwall, contamination by flood water or other surface water seeping in through a damaged well head or lining, contamination by debris (and possibly bodies) falling in. They may also dry up, partially or completely, if groundwater conditions change.

If a well has become contaminated, been blocked with debris or the sidewalls have collapsed:

- Lower the water level as much as possible by rapid, continuous pumping (a suitable, not directly coupled motorized pump is needed; then
- Take out any solid debris, and inspect and clean/repair the inside of the lining.

**Construction of new tube wells**

Before investing hope or resources in any drilling operations, check existing hydrogeological data or organize necessary surveys to confirm whether water of acceptable quality is likely to be present with worthwhile yields in the localities concerned.

When drilling is to be undertaken, ensure all necessary inputs including technical expertise, skilled labour, tools, equipment, pipes, screens, pumps, transport, and funds for operating expenses.

Where deep groundwater is being sought, organize rapid test drilling (using rotary rigs) where survey data is encouraging – immediately develop those ‘exploratory’ holes that yield adequate water into production wells (by enlarging the hole and installing the necessary lining, well pipes and pumping mechanisms).

**Hand-dug wells**

Hand-dug wells can satisfactorily meet the requirements of very large populations in some circumstances, e.g. more than a million Afghan refugees in Pakistan in 1982/1983. Depending on the soil conditions, wells may be dug to as much as 40 metres in depth. Experienced, skilled labour must be mobilized, especially for operations below 5 m depth (see also Panel 8).

If water is seeping into the well through the lining (within 3–6 m of the surface):

- The lining must be renewed or improved; patching is rarely successful.
- As an alternative to replacing the lining, the soil around it may be dug out to a depth of about 3 m and filled in with puddled clay (see Panel 11).
- A layer of concrete reinforced with wire mesh should, if possible, be placed between the old lining and the clay.

In all cases:
• Inspect the headwall and protective apron; repair or replace as necessary, including the pulley or rollers for lowering the bucket; then

• Thoroughly wash down and, if possible, disinfect the well.

A pot chlorinator may afterwards be suspended in the well to continuously disinfect the water if necessary. Especially if the well has been seriously contaminated, scrub the lining and inside wall with a strong chlorine solution (see Panel 12) – particularly between the current low water level and the highest point to which water is expected to rise. Then pour a quantity of the same solution into the well and agitate the water by raising and lowering a bucket in it. Leave for 12 hours if possible. (Also, if possible, estimate the quantity of water in the well. Pour in 5 litres of the strong chlorine solution for every 100 litres of water in the well and add more if the residual chlorine concentration is less than 0.3 mg/l after an hour.)

Deepening dug wells

If a well has run dry or the yield is inadequate, seek water at a greater depth by:

• Deepening the well itself; or
• Sinking a tube well into the bottom of the well and mounting one or several handpumps fitted to a concrete slab (with a manhole) sealed over the wellhead (see Panel 12).

Alternatively, yield may be able to be increased by driving perforated pipes radially outward from the bottom of the well into the surrounding soil across the direction of flow of the groundwater, but this may be less cost–effective.

Digging a new well

The requirements for digging a new well are similar to those of rehabilitating an old one, although more time and larger quantities of materials (especially concrete) are required:

• Choose the site carefully, where water is known to be available at not too great a depth and well away from sanitation facilities; and

• Disinfect the well before use, as for a rehabilitated well.

Water will often be found at shallow depths close to riverbanks and lakes, also in low–lying places where the vegetation is rich.

Sub–surface dams

Where rivers have dried up and the riverbed is of sand, gravel or shale, water may still be flowing in the riverbed itself. If so, it may be possible to access this water by constructing sub–surface dams across the flow and then leading the retained water off to wells in the river bank. Such operations, organized by OXFAM, were successful in helping to meet the needs of 40,000 refugees in northern Somalia in 1982/1983.

First determine whether sub–surface water is present by digging in the riverbed until hard rock or impervious clay is reached. If water is present:

1. Dig a trench right across the bed down to the impervious layer;

2. Construct a dam using rocks (and concrete, if necessary and available) to a level below that of the riverbed itself;

3. Construct an infiltration gallery (stone–filled trench) across the riverbed a short distance upstream of the dam and extending some metres into the dry riverbank;

4. Dig/sink a well in the bank to intersect with the infiltration gallery to extract the water (see Panel 13). Water obtained in this way is often of good quality unless it is flowing close to the soil surface.
Surface water

Water in streams, rivers, ponds, lakes and reservoirs is rarely safe. It needs to be improved in quality and, if possible, treated before it is used for drinking.

If the source holds water all year round:

- Dig/sink shallow wells near the banks if these are porous (the water table can be expected to be near the surface); or
- Install a riverbed filter if the bed of the lake or river is sandy.

If this is not feasible – if, for instance, the ground is not sufficiently porous – the surface water may have to be drawn directly. The quality and safety of the water can then be improved by one or a combination of: storage and sedimentation, slow sand filtration, and/or chemical treatment (see annex 3). Regardless of how the water is to be extracted and treated:

- Draw water as far away as possible from and in the case of a river upstream of any other human or animal use;
- Fence off the area of the bank where drinking water is to be drawn off and, if necessary, organize guards to prevent pollution by keeping people and animals away; and
- Designate other areas, downstream, for washing and watering animals.

Lake/river bed filters

If the bed of the lake or river source is permeable, dig a filter box into the bed as shown in Panel 14 and pump water out directly to storage tanks. This method has been used successfully in lakes and slow−flowing rivers, but it is difficult to construct and operate in fast−flowing rivers.

The watertight box is open at the bottom and has a filter plate sealed into it about 1/3 from the top. The fine slots in this plate (‘septum’) should, if possible, taper outward towards the top so that sand particles do not clog it. The box itself is normally made of reinforced steel, but it is possible to improvise with other local materials.

Initial rapid pumping will build up a graded layer of soil below the filter plate, after which normal pumping will deliver properly filtered supplies.

Maintenance of systems

The breakdown of a pump or any other component of an extraction and delivery system can have disastrous consequences for the population. Ensure arrangements for regular maintenance and prompt repairs, including:

- Defined responsibilities for maintenance (if possible, by designated community members);
- Training and tools for local operators and mechanics;
- Availability of sufficient, appropriate spare parts; and
- Availability of spare/standby pumps (that can be used while one which has broken down is being repaired).

- If power supplies are intermittent and/or have poor quality, large main pumping motors should be fitted with controllers providing protection for voltage/phase fluctuations and
Establish systems by which spares and expert mechanics can be mobilized very quickly whenever needed.

**Possible UNICEF inputs**

Depending on the assessment of actual needs and possibilities, some of the following inputs might be considered:

**General**

- Expertise to help plan and implement appropriate programmes: hydrogeologists, water engineers, sanitarians, drillers, and mechanics, including mobilizing locally available technical expertise.

- Laboratory equipment and/or small field-test kits ('portable water analysis' kits) for water-quality testing.

- Chlorine chemicals for disinfecting wells and associated installations.

- Local costs for operations, including maintenance of installations (preferably by the motivation and training of local populations).

**Rainwater collection**

- Materials for the rapid repair/construction of guttering.

- Containers – jerry cans or buckets with lids – for households to collect and store water.

- Local costs for the establishment of collection systems at feeding centres, health centres and hospitals.

**Natural springs**

- Materials and, possibly, local costs for the repair/construction of spring ‘boxes’ and associated storage and distribution arrangements.

**Tube wells (boreholes) and hand-dug wells**

- Expertise and/or local costs for expert surveys of wells and, if needed, the groundwater potential.

- Tools: spades, buckets, block-and-tackle, pliers, trowels, levels, cutlasses, measuring tapes, rope, hard hats, etc.

- Pipes, screens, cement, reinforcing bars, etc., for the (re) construction of wells.

- Spare parts and/or new pumps.

- Local operating costs for repair and construction work.

- Drilling equipment, supplies and spare parts.
Surface water

- Tools and materials for the construction of storage tanks, filter units, etc.
- Pumps for raising/moving water.

Further Guidance


Self-help wells, R. G. Keogel, FAO irrigation and drainage paper No.3 – FAO (1977)


Water supply for rural areas and small communities, E. Wagner & J. Lacroix – WHO (1959)


Aqua Plus – UNICEF


Panels

Panel 1 – Water Sources and their Utilization

<table>
<thead>
<tr>
<th>Source</th>
<th>Treatment</th>
<th>Extraction</th>
<th>Distribution</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rain</td>
<td>Unnecessary if catchment and receptacles clean.</td>
<td>Channeling off suitable roofs and/or hard grounds.</td>
<td>Collection directly at household or institutional level.</td>
<td>Useful as supplementary source of safe water in certain seasons.</td>
</tr>
<tr>
<td>Ground Water</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural spring</td>
<td>Unnecessary if properly protected</td>
<td>Simple gravity flow; preferably piped from a protective ‘box’.</td>
<td>Individual collection directly via storage tanks or gravity-fed distribution systems.</td>
<td>Source must be protected; yield may vary seasonally.</td>
</tr>
<tr>
<td>Deep well (low water table)</td>
<td>Unnecessary if properly located, constructed and maintained.</td>
<td>Handpump possible if water table less than 60m deep and output required is low, otherwise motor pumps necessary.</td>
<td>Individually pumped by hand, or motor pumped to storage tanks, possibly linked to distribution systems.</td>
<td>Yield unlikely to vary much with seasons unless prolonged drought. Special construction equipment and expertise required. High yields often possible.</td>
</tr>
<tr>
<td>Shallow well (high water table)</td>
<td>Unnecessary if properly located, constructed and maintained.</td>
<td>Hand pump or hand drawn container.</td>
<td>Pumped or drawn directly from wells by individuals.</td>
<td>Yield may vary seasonally: can be dug/drilled by local skilled labour. Care needed to avoid pollution.</td>
</tr>
<tr>
<td>Surface Water</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flowing (stream, water)</td>
<td>Often necessary: sedimentation, filtration and/or chlorination.</td>
<td>Preferably pumped to storage and treatment tanks.</td>
<td>Individual collection preferably from storage/ treatment tanks.</td>
<td>Yield may vary seasonally: access to source should be controlled.</td>
</tr>
<tr>
<td>Standing (lake, pond)</td>
<td>Always necessary, as above.</td>
<td>As above.</td>
<td>As above.</td>
<td>As above.</td>
</tr>
</tbody>
</table>

Panel 2 – Criteria for Choosing Between Alternative Sources

**CRITERIA FOR CHOOSING BETWEEN ALTERNATIVE SOURCES**

- Speed with which sources can be made operational;
- Potential yields;
- Reliability of supply (taking into account seasonal variations and, if necessary, logistics);
- Water purity, risk of pollution and ease of treatment if necessary;
- Simplicity of technology and ease of maintenance;
- Costs; and
- In the case of displaced populations, the rights and welfare of the local, indigenous population.

Panel 3 – Determining Feasible Means of Supply

**DETERMINING FEASIBLE MEANS OF SUPPLY**
Panel 4 − Estimating Potential for Rainwater Collection

ESTIMATING POTENTIAL FOR RAINWATER COLLECTION

One millimetre of rainfall on one square metre of roofed area gives 0.8 litres on average, after allowing for evaporation.

Thus, if the roofed area measures 3 m x 4 m and the rainfall which may on average, be expected during a particular month is 120 mm, the amount of rain water which might be collected in that month is:

$$3 \times 4 \times 120 \times 0.8 = 1,152 \text{ litres}$$

i.e. an average of about 38 litres per day – sufficient to meet the survival needs of 8 people, or the normal minimum requirements of 2–3 people. (The rainfall may, of course, not be spread evenly throughout the month and, if the rains fail, there could be none).

Panel 5 − Protection of a Natural Spring Source by a “Box”

PROTECTION OF A NATURAL SPRING SOURCE BY A “BOX”
### Panel 6 – Characteristics of Different Types of Well Construction

<table>
<thead>
<tr>
<th>Type of well</th>
<th>Approximate maximum depth</th>
<th>Technique</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driven tube well</td>
<td>10–15m</td>
<td>Pipe with special tip is hammered into ground. Can be sunk in 1–2 days.</td>
<td>Small. Cannot be sunk in heavy clay soil or rock. Needs special filter ‘well point’ at tip of pipe.</td>
</tr>
<tr>
<td>Auger–bored tube well</td>
<td>25m</td>
<td>Hole bored by hand using a suitable auger (different augers for different soils). Can be sunk in 2–3 days.</td>
<td>Larger than driven tube well. Augers may need to be imported but locally available boring tools can often be used.</td>
</tr>
<tr>
<td>Hand dug well</td>
<td>30–40m</td>
<td>Requires skilled workers otherwise dangerous. Speed depends on soil conditions: 2–10m per week for a team of 4–8 men.</td>
<td>Needs no pump, but easily contaminated by misuse or if workmanship is poor. Convenient where such wells are traditional and other equipment/materials lacking.</td>
</tr>
<tr>
<td>Jetted tube</td>
<td>80m</td>
<td>Water is pumped down the well pipe to loosen and carry soil back up out of the hole thus enabling the pipe to be driven further down.</td>
<td>Process of sinking requires much water. Can be done by hand in delta areas with little equipment but skilled labour; otherwise special drilling equipment needed.</td>
</tr>
<tr>
<td>Drilled tube well (bore–hole)</td>
<td>Over 100m</td>
<td>Large mechanized drilling rig. Several days depending on soil/rock conditions</td>
<td>Expensive equipment requiring skilled operators, good maintenance, sufficient tools, fuel, and efficient logistic support.</td>
</tr>
</tbody>
</table>

The yield potential of a well depends on the geological formation in which it is sunk, the contours and gradients of the land, the well construction. Actual output up to that maximum depends on the pump. If wells are sited too close together, yields will be reduced.
Precautions when digging/deepening hand-dug wells

For depths greater than 5m, ensure:

- The provision and use of safety ropes, and the capability at all times to evacuate workers from the bottom of the well;
- Sufficient light using mirrors and flashlights; and
- Adequate aeration/ventilation of the well before workers descend and while they work.

Where it is necessary to continuously pump water out of a well ('de-watering'), use an electric or preferably compressed-air-operated pump, with the generator or compressor well away from the well. Never use a petrol or diesel motor inside a well.

Raising and lowering a large bunch of leaves inside the well for some time may be sufficient to purge the air within many wells.

For very deep wells and any where there is a risk of toxic fumes entering the well (and accumulating at the bottom):

- Lower a lighted candle first: if it goes out there is excessive carbon dioxide in the well which must therefore be ventilated before anyone descends; and
- Ensure continuous aeration using a fan or suitable compressor (with a oil filter fitted on the
Panel 9 – Typical Dug Well Installation

**TYPICAL DUG WELL INSTALLATION**

- Headwall high enough to prevent contamination, narrow enough not to be stood on.
- Surface water run-off in rainy areas.
- Narrow impervious sloping apron to avoid mud and stagnant water.
- Drainage to soak away or ditch.
- Sides sealed for 3m below ground.
- Simple wooden windlass close to headwall may be useful - check local practice.
- Single public tethered container: use of individual containers prohibited.
- Hoist arrangements should avoid drawings тея over well leg, pulleys or rollers.

Panel 10 – Preventing pollution of a dug well

**Preventing pollution of a dug well**

Users’ own containers must never be lowered into a well. One or two special containers must be fixed in place and be used by everyone.

The captive bucket/container should be lowered either from a pulley suspended above the well or across a roller/bar fixed across the headwall. The bucket must not scrape the side of the well.

A solid concrete apron should be constructed at least 1m wide and sloping away from the well in all directions to a gutter which leads to a soakage pit, preferably filled with stones or gravel, 10m away.

A headwall about 50cm high should be sealed into the apron: it should not be so wide that people can stand on it.

Prevent anything falling or being thrown in the well. Cover it, if possible, when no one is using it.

If heavy rains are expected, dig a drainage ditch around the well about 10m away with a channel to lead excess surface water away, possibly to the soakage pit.

Panel 11 – An Improved Dug Well

**AN IMPROVED DUG WELL**
Panel 12 – Preparation of a ‘strong’ chlorine solution

<table>
<thead>
<tr>
<th>Chemical source</th>
<th>% available chlorine</th>
<th>Quantity required</th>
<th>Approximate measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleaching powder</td>
<td>35</td>
<td>6g</td>
<td>1 dessertspoon</td>
</tr>
<tr>
<td>Stabilised/tropical bleach</td>
<td>25</td>
<td>8g</td>
<td>1 tablespoon</td>
</tr>
<tr>
<td>High test hypochlorite solution</td>
<td>70</td>
<td>3ml</td>
<td>1 teaspoon</td>
</tr>
<tr>
<td>Liquid laundry bleach</td>
<td>5</td>
<td>40ml</td>
<td>3 tablespoons or 5 dessertspoons</td>
</tr>
<tr>
<td>Liquid laundry bleach</td>
<td>7</td>
<td>30ml</td>
<td>2 tablespoons</td>
</tr>
<tr>
<td>Javelle water</td>
<td>1</td>
<td>200ml</td>
<td>1 teacup or 6oz milk tin</td>
</tr>
</tbody>
</table>

This ‘strong’ solution contains 0.02% chlorine = 0.2g of chlorine/litre = 200mg/litre = 200ppm (‘parts per million’).

Avoid skin contact with any of the chemical sources or the strong chlorine solution. Avoid inhaling the chlorine fumes.

Panel 13 – Sub–Surface Dam and Infiltration Gallery

SUB–SURFACE DAM AND INFILTRATION GALLERY
Chapter 17 – Annex 3: Water Quality and Treatment

Objective

To ensure that water is safe for human consumption, safe from harmful pathogens, chemical contamination and agricultural and industrial pollutants.

Methods and Priorities

- Avoid the need for any treatment by finding good quality sources, if possible, and give high priority to preventing contamination.
• Improvement/treatment, where necessary, should be the minimum required to ensure acceptably safe water, using appropriate technology and a method that is reliable.

• Contaminated water in municipal piped systems can spread disease very quickly. Frequent testing of water is needed where such systems exist.

If water needs to be improved/treated on a large scale: mobilize sanitary engineers to determine how it should best be done and to organize the operation and maintenance of appropriate systems.

In all cases, give high priority to domestic hygiene and measures to protect the water between collection and use.

**Dangers and Sources of Contamination**

The greatest risk associated with polluted drinking water is the spread of diarrhoeas, dysenteries – caused by a variety of viruses, bacteria and protozoa – and infectious hepatitis. The pathogens (disease-causing organisms) are largely transmitted in faeces:

• Contamination by human faeces is the major concern, although animal (and bird) faeces in water may also cause disease transmission.

• Children’s faeces are more dangerous than those of adults.

• Contamination by urine is a significant threat only in areas where urinary schistosomiasis is endemic.

Panel 1 lists the priorities for testing water quality and the possibilities for improving it when necessary.

**Improvement/Treatment Methods**

Chemical treatment is the surest way of making water safe for drinking, but such treatment must be properly controlled and supervised on a continuous basis. Except in the context of well-established municipal systems, or situations where adequate numbers of competent sanitation personnel are on the spot, this may be difficult to assure. Chemical treatment may, however, be appropriate for supplies for hospitals, feeding centres, etc.

Storage plus slow sand filtration requires considerable effort – and materials – at the outset to establish the systems (tanks, etc.) but, once set up, should be able to be operated by suitably instructed members of the community with only occasional inspection/supervision by professional sanitarians. (Where a system serves a large community, those responsible for its day-to-day operation may need to be remunerated.)

Water purification tablets and boiling are rarely appropriate for water treatment on a large scale, but may be used in hospitals, feeding centres, etc. In many situations, storage/sedimentation followed by slow sand filtration or chemical treatment in separate storage tanks is the best approach.

**Testing Water Quality**

Samples should, if feasible, be sent to a public health laboratory for expert analysis. Otherwise they may be tested on the spot by trained sanitarians using field test kits.

Taking samples requires no particular expertise, but it does take considerable care (see Panels 2, 3a and 3b). Samples should, to the extent possible, be kept cool and in the dark. They must reach the laboratory – or be analyzed in the field – within 24 hours of collection.

The actual test done will depend on the normal practice of local water laboratories and the experience of the local sanitarians. The most widely used tests are those that detect and enumerate faecal coliforms (see Panel 4). Membrane filters will probably be required for field-testing.
In cases where the water is already being disinfected by chlorination, it is easier and more appropriate to test for the presence of chlorine than for bacteria directly. If chlorine is present at concentrations of 0.2–0.5 mg/litre at the distribution point, the water can be considered safe of harmful pathogens. Residual chlorine test kits will be required.

Storage/Sedimentation

Leaving water undisturbed in large tanks – or household containers – improves its quality as many pathogens die off and any heavy matter in suspension settles out (sedimentation):

- Storage of untreated surface water for 12 to 24 hours brings about an appreciable improvement in its quality.
- The longer the period of storage and the higher the temperature, the greater the improvement.
- Storage for 48 hours helps to prevent transmission of bilharzia, provided snails do not enter the tank.

Storage tanks should be covered; the dangers of contamination of open tanks more than offset the advantages of direct sunlight.

The storage area should be fenced off and, if necessary, guarded, to prevent children playing in the water.

Storage capacity should, if possible, be equivalent to at least 24 hours, requirements for the population to be served.

A two–tank system is often used:

- The first tank is the settling tank in which water is left undisturbed for at least 48 hours, and longer if possible.
- The clarified water is then transferred to the second tank from which it can be used. The sludge at the bottom of the first tank is discarded.

If treatment is still required, the water can be chlorinated in the second tank before it is used. If the bottom of the first tank is above the top of the second, the clarified water can simply be drained or siphoned from the first into the second.

The numbers of viruses and protozoa in stored water decreases with time. They decrease most rapidly at warm temperatures. Bacteria generally behave similarly but, in exceptional circumstances, may multiply in polluted water. The dose of bacteria needed to establish an infection in the intestine may be large, however, whereas the infectious dose of viruses and protozoa is typically very low. Prolonged storage, therefore, greatly reduces the dangers.

Schistosomiasis (bilharzia) parasites die if they do not reach the freshwater snail within 24 hours of excretion by an infected person, or a human or animal host within 48 hours of leaving infected snails.

The stirring–in of some dissolved alum (aluminum sulphate) crystals accelerates the sedimentation process but not the dying off of pathogens. 50–500 g of crushed alum is required for every 1.000 litres of stored water, depending on the alkalinity of the water. Dissolve it in a bucket of water first.

Slow Sand Filtration

As water passes through fine sand, solid particles are filtered out and, more important, the thin layer of microorganisms that develops on the surface of the sand bed breaks down any organic matter in the water.
Panel 5 and Panel 6 provide brief details of the ‘packed−drum’ filter that can provide 40–60 litres of good quality water per hour for health and feeding centres, or drinking water for small groups of households. The referenced publications provide details for the construction of larger systems that can deliver 100 litres/hour for every square metre of filter surface area. They may, however, not be practicable in many emergency situations.

Chemical Disinfection

Chemical treatment of water on a large scale is, as a rule, recommended only in situations where storage and/or filtration cannot meet the need. All disinfection systems require close control and supervision. They are of little value unless fully reliable. Get expert advice.

Chemical disinfection of new and rehabilitated wells, sand filters, pumps and piped water systems is, however, essential.

Chemicals

The most generally available chemical suitable for use in emergencies is bleaching powder (calcium hypochlorite). ‘High Test Hypochlorite’ solution, if available, has advantages. Liquid bleach and Javelle water can also be used. Note that:

- Each of these products contain a different amount of usable chlorine, hence different quantities of each are required for the same purpose. All lose active chlorine over time.
- All chemicals and made–up solutions should be stored in tightly closed containers made of dark coloured glass, ceramic or plastic (not metal), and kept in a cool dark place.
- For small–scale operations, it is best if chemicals are delivered in small–sized containers (e.g. 1 kg plastic bags).

Chlorination in Storage Tanks

Chlorination should normally be undertaken after an initial sedimentation or filtration process. The quantity of chlorine required depends on the degree of pollution and the amount of sediment in the water.

1. Prepare a 1% chlorine solution (see Panel 7).
2. Pour sufficient of the 1% solution into the tank to produce an initial chlorine concentration of 5−7–mg/litre (see Panel 8).
3. Leave for at least 30 minutes (1−2 hours if protozoa or helminths are likely to be present); then
4. Test the water to determine the residual chlorine content. Add more chlorine solution or neutralize excess chlorine as necessary (see Panel 8).

Field ‘residual chlorine test kits’ are available. Only basic laboratory experience is required to use them. After treatment, adding a little sodium thiosulphate (‘Hypo.’) may if necessary, neutralize excess chlorine: 1 crystal to a litre of water, 4−5 crystals to a bucketful.

Chlorination in Dug Wells

If it is necessary to chlorinate water in a dug well, and little equipment or technical expertise is available, a pot chlorinator may be suspended in the well − 1 metre below the water level. This requires some expertise, but
as a general indication:

- A single pot chlorinator (see Panel 9a) may be sufficient to treat a well or tank being drawn on at a rate of about 1,200 litres/day (say 60 people). It would need to be replaced every 1−2 weeks.

- A double pot chlorinator (see Panel 9b) would be sufficient to treat a well being drawn on at about 400 litres/day (say 20 people). It should be replaced every 2−3 weeks.

The pot should have a total capacity of 12−15 litres and contains 1 kg of bleaching powder mixed with 2 kg coarse sand.

The outer pot should be about 25 cm diameter and 30 cm high; the inner pot about 16 cm in diameter and 28 cm high. It should contain 1.5 kg bleaching powder mixed with 3 kg coarse sand, then moistened. The hole in the inner pot should be about 3 cm above the level of the mixture.

Drip Chlorinators

Various types of drip chlorinators can be constructed to feed a chlorine solution very slowly into a water supply that is being used (flowing) continuously (see referenced publications).

Boiling

Boiling is the surest method of water sterilization, but is not practical for the needs of large populations especially when fuel is short. It should be relied on to purify drinking/domestic water supplies only if the people have traditionally boiled their water and have sufficient fuel to continue to do so.

At low altitudes, simply bringing water to the boil will destroy all pathogens that may be transmitted by drinking water. As a rule of thumb, boiling should be continued for one minute for every 1,000 metres of altitude above sea level, as the boiling temperature reduces with altitude.

Prolonged vigorous boiling is often recommended but is not necessary to destroy the faecal orally transmitted pathogens. It is wasteful of fuel – boiling requires about 0.5 kg of wood per litre of water – and evaporation of the water will increase the concentration of nitrates, which could then be dangerous for very young babies.

Mobile Drinking Water Units

Trailer−mounted drinking−water units – comprising a motorized pump, hypochlorinator and filter – are available, which are said to be capable of delivering up to 50,000 litres of good quality water per hour. Where local infrastructure is well developed and expertise exists to operate such units, they have been valuable for short−term use after certain high−impact disasters: e.g. in Lebanon and in Peru.

Units may be available from the local military or rescue services. They might be obtainable as in−kind contributions from major donors. Supply Division can provide information on purchase possibilities.

Ensure operators are trained, maintenance procedures observed, and sufficient stocks of fuel, other consumables and spare parts for the expected service period of the plant are securely stored and monitored.

Possible UNICEF Inputs

Depending on the assessment of actual needs and possibilities, some of the following inputs might be considered:

- Expertise – experienced sanitarians – to help in planning, organizing and supervising
operations (in conjunction with WHO).

- Bleaching powder or other chemicals.
- Local costs for the establishment of storage, filtration and/or treatment units.

Further Guidance

Water Testing

Guidelines for drinking water quality, vol.1 (recommendations) and vol.3 (drinking water quality control in small–community supplies) – WHO (1993)


Water Treatment


Safe drinking water, J. Howard – OXFAM, Oxford (1979)


Water Manual for Refugee Situations, UNHCR (1992)


Water Supply Options for Guinea Worm Eradication and Health Improvements in Rural Areas–UNICEF (1994)

Panels

Panel 1 – Testing and Improving Quality of Water

<table>
<thead>
<tr>
<th>TESTING AND IMPROVING QUALITY OF WATER</th>
</tr>
</thead>
<tbody>
<tr>
<td>If possible, test the water at source, in storage tanks and in tanker trucks:</td>
</tr>
<tr>
<td>• Before any new source is used;</td>
</tr>
<tr>
<td>• At regular intervals during use; and</td>
</tr>
<tr>
<td>• Whenever any contamination – especially by faeces – is suspected</td>
</tr>
</tbody>
</table>

It must be tested immediately when any outbreak of a typically water–borne disease is reported.

Water may be improved/treated by:

• Covered storage for 1–2 days (during which many viruses, protozoa and bacteria die off and solid particles settle out).
- Slow sand filtration in specially constructed filter units, which effectively removes protozoa, most bacteria and solid particles.
- Chemical treatment, normally with a chlorine-based compound, which kills bacteria, viruses and protozoa.
- Boiling, which kills bacteria, viruses and protozoa.

Panel 2 – Taking Water Samples

<table>
<thead>
<tr>
<th>TAKING WATER SAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Collection Bottles</strong></td>
</tr>
<tr>
<td>Bottles should be sterile and have an airtight seal. Don’t fill them completely. Tie a piece of greaseproof paper or aluminum foil over each cap after closing it.</td>
</tr>
<tr>
<td>Ideally, 100–200 ml glass bottles with ground glass stoppers or rubber-lined screw tops should be used. They should preferably be autoclaved—e.g. in a pressure cooker for 40 mins.—after first tying a piece of brown paper securely over the open mouth and wrapping the cap in similar paper. In practice, Coca-Cola or similar fizzy drink bottles can be used if new caps and a manual-capping machine are available (e.g. Supply Division 20–515–20 + 20–525–00). The caps must also be wrapped and autoclaved.</td>
</tr>
<tr>
<td>If sampling from a chlorinated supply, put a few drops of 10 per cent sodium thiosulphate solution in each bottle first.</td>
</tr>
</tbody>
</table>

**Sampling from surface water**

Take samples at least one metre from the bank and 20–30 cm below the water surface: see Figure 18/a.

If schistosomiasis is prevalent, protective boots and gauntlets should be worn if risks of contracting the disease are to be avoided.

**Sampling from a dug well**

Lower a weighted sampling bottle into the well without touching the sides: see Figure 18/b, and Take samples separately from water raised in the captive communal bucket (to check whether the bucket itself is contaminated).

**Sampling from a tube well pump**

1. Wipe the mouth of the pump with a clean rag;
2. Operate the pump for long enough to clean out the water standing in the well tube;
3. Sterilize the mouth of the pump with a gas or alcohol flame, if possible; then
4. Take a sample holding the bottle in the middle of the stream of water.

**Sampling from a tap**

1. Wipe the mouth of the tap with a clean rag;
2. Run the water fast for at least 1 minute;
3. Sterilize the mouth of the tap with a gas or alcohol flame, if possible;
Panel 3 – Sampling From a Stream

Panel 4 – Faecal Coliform Levels

<table>
<thead>
<tr>
<th>FAECAL COLIFORM LEVELS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The presence of faecal coliforms indicates that the water has been contaminated by faeces of human or other warm-blooded animals. Concentrations are usually expressed per 100ml of water. As a rough guide:</td>
</tr>
<tr>
<td>0–10 Faecal coliforms/100ml = reasonable quality</td>
</tr>
<tr>
<td>10–100 Faecal coliforms/100ml = polluted</td>
</tr>
<tr>
<td>100–1,000 Faecal coliforms/100ml = dangerous</td>
</tr>
<tr>
<td>Over 1,000 Faecal coliforms/100ml = very dangerous</td>
</tr>
</tbody>
</table>

Panel 5 – Packed Drum Filters

<table>
<thead>
<tr>
<th>PACKED DRUM FILTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requirements:</td>
</tr>
<tr>
<td>• A suitable drum with a cover (e.g. an empty 200 litres vegetable oil drum; empty fuel drums can be used but not drums which have contained chemicals).</td>
</tr>
<tr>
<td>• Pipes, pipe fittings, taps, sand, gravel, tools</td>
</tr>
<tr>
<td>Preparation</td>
</tr>
<tr>
<td>1. Thoroughly clean the drum; drill holes and fit pipes; then disinfect the drum with a strong chlorine solution.</td>
</tr>
<tr>
<td>2. Put large gravel in the bottom to a level of 5cm above the bottom (outlet) hole.</td>
</tr>
<tr>
<td>3. Filled with washed sand (grain size in the range 0.2–0.5cm) to a depth of 75cm.</td>
</tr>
<tr>
<td>4. Disinfect by filling with a strong chlorine solution and leaving for 12 hours.</td>
</tr>
<tr>
<td>5. Flush out with water until there is no longer a strong smell of chlorine.</td>
</tr>
</tbody>
</table>
Operation/use

The rate of drawing water must never exceed 60 litres per hour:

- If possible, establish a continuous, slow flow: feed water into the filter from another tank at a higher level through a valve adjusted to allow a flow of not more than 1 litre/minute – collect the filtered water in another storage container.

- Otherwise, simply draw water off from a tap at the bottom and immediately add a similar quantity of unfiltered water to the top.

Cleaning

Clean the filter occasionally but not too often – when the rate of flow has fallen significantly:

1. Drain off the top water.
2. Scrape off and discard the top 1–2cm (3/4") of sand.
3. Loosen the new surface of sand, then restart the filtration.

Top up with fresh, washed sand occasionally.

The never must never be allowed to run dry. There must always be a layer of water above the surface of the sand.

Panel 6 – Packed Drum Filter

Panel 7 – Preparation of 1 per Cent Chlorine Stock Solution

<table>
<thead>
<tr>
<th>Chemical source</th>
<th>% available chlorine</th>
<th>Quantity required</th>
<th>Approximate measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleaching powder</td>
<td>35</td>
<td>30mg</td>
<td>2 heaped tablespoons</td>
</tr>
<tr>
<td>Stabilised/tropical bleach</td>
<td>25</td>
<td>40mg</td>
<td>3 heaped tablespoons</td>
</tr>
</tbody>
</table>
### Panel 8 – Disinfecting Water Using 1 per Cent Stock Solution

<table>
<thead>
<tr>
<th>Volume of water to be disinfected</th>
<th>Quantity of 1 per cent solution (ml)</th>
<th>Approximate measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 litres</td>
<td>5–7</td>
<td>1 1/2 teaspoons</td>
</tr>
<tr>
<td>50 litres</td>
<td>25–35</td>
<td>2 tablespoons</td>
</tr>
<tr>
<td>100 litres</td>
<td>50–70</td>
<td>4 tablespoons</td>
</tr>
<tr>
<td>1,000 litres</td>
<td>500–700</td>
<td>3 teacups or 6oz milk tins</td>
</tr>
</tbody>
</table>

Leave the water to stand for a least 30 minutes, then test it to determine the residual chlorine content:

- If concentration is 0.2–0.5mg/litre (or more), all harmful organisms will have been killed and the water can be used.
- If concentration is less than 0.2mg/litre, add more 1% solution, wait 30 minutes and test again.
- If concentration is greater than 0.5mg/litre, the water may taste unpleasant: neutralise the excess chlorine (see below) and add less of the 1% solution to the next batch of water.

### Panel 9a – Single Pot Chlorinator

**SINGLE POT CHLORINATOR**

- mouth open
- stones
- coarse sand and bleaching powder
- gravel
- stones (20-40mm)
- 6-8 holes 5mm diameter
Chapter 17 – Annex 4: Water Pumps, Pipes and Fittings

Pumps

Pumps may need to be repaired, replaced or newly provided to raise water for direct distribution at a well and/or to move it through pipelines to storage tanks or other distribution points.

In most areas, hand-operated pumps are to be preferred, especially where they are already familiar locally and fuel supplies cannot be guaranteed. They are relatively easy to install and maintain, generally more reliable than motorized pumps and less dependent on supplies of spare parts as well as fuel from outside the community.

Motorized pumps – which can raise water much faster and from greater depths – may, however, be indispensable if the needs of large number of people have to be met from only a few sources, and those sources have high yield potentials. Regular maintenance and prompt repair/replacement in case of breakdown must be assured, as well as regular fuel/power supplies.

Caution: Poor initial installation is probably the most common reason for the premature breakdown of any pump.

Handpumps can be used to raise the water if the water table is not more than 50–60 m deep, and the available yield and/or required output is low. If the water table is less than 7 m deep (shallow well), suction pumps with the operating cylinder at the top (ground level) can be used. Otherwise, the cylinder must be ‘down the well or borehole’ in the column of water, and the pumps are generally known as deep-well handpumps. In some countries, an intermediate pump is used whose range is 0–15 m.

Yields of 750–900 litres/hour can be possible – about 10 cubic metres per day, assuming continuous pumping for 12 hours. This could be sufficient, in theory, for 1,000 people. In practice, actual performance may be less than half of this.

The type of handpump already familiar in the area should normally be provided. ‘Experiments’ should generally be avoided in the emergency phase. (Alternatives and refinements may be considered in the context of any long-term rehabilitation-cum-development programme when close, continuous supervision of all pump installations by a competent technician can be assured.)

Handpumps should be ordered together with rising main pipe, connecting rods, cylinders, spare parts, tools and installation/maintenance manuals. If groundwater is highly corrosive, plastic or stainless steel pipe with stainless steel connecting rods should be considered.
Motorized Pumps

Get advice from professionals, local technicians and community leaders regarding the selection and siting of pumps. The major considerations in pump selection are: local familiarity, fuel or electrical supplies, availability of spares, proper installation, ease of maintenance, and, above all, reliability.

Alternative types are submersible electric pumps fitted ‘down the well’ or mechanical shaft−drive pumps. Self−priming centrifugal pumps are usually recommended when water has to be lifted a considerable height (up to 100 metres) or pumped over a long distance. Low−speed pumps generally cause fewer operational problems and have a longer life than high−speed units.

Panel 1 lists some of the main aspects to be considered and specified when ordering pumps. Any requirements for an initial stock of spare parts must also be stated at the time of ordering.

Obtain a list of all the pump types in use and a list of the spare part usage over the last year to determine what parts should be provided to keep the system running over the next specified period. An initial URGENT list for parts needed immediately and backups parts for critical pumps and accessories can be followed by a stock list sufficient for the period. Any new pumps and accessories should be compatible with existing ones where possible so maintenance stocks and staff expertise can be utilized.

If spare parts are required to repair an existing pump, quote the make, model number and serial number of the pump.

Provided tank storage capacity is sufficient to meet peaks in demands during the day, the delivery capacity required of the pump is determined by dividing the total daily output needed by the number of hours the pump will be run each day. It must not be greater than the yield of the source concerned. Provide for some spare capacity to cover breakdowns, any possible increases in population, etc.

In most cases, pumps will normally be left idle for a sufficient period each day to allow the water in the source to recover to its original level. If the pump output is greater than the yield of the well, the latter may be pumped dry and the pump itself may then burn out.

Solar (photovoltaic) Pumps

In some circumstances pumps powered by solar panels may be suitable. The present generation is still expensive for their output but very reliable and involve no direct running costs.

Such pumps naturally work best in direct sunlight but will still work with light cloud cover. As a rough indication, a solar pump powered by panels rated at 450W would lift 1−2 litres/second through 6 metres on a sunny day. Thus a solar pump might be a solution when the output of a hand pump would be insufficient but the high output of large mechanized pumps are not necessary.

Solar pumps performed well in refugee camps in Somalia delivering 55−75 cubic metres per day on an 8 m head.

Windmills

Windmills may be considered where wind speeds of at least 8 kms/hour (5 miles/hr.) can be expected for 60% of the time throughout the year. Some windmills can be connected to handpumps, which can be operated by hand when necessary.

Pipes and Fittings

Requirements for pipes and pipefittings must be specified by experienced, practical technicians, but note that:

• Plastic pipes are usually cheaper and easier to install than other types.
• Plastic pipes can usually be glued together, but different solvents (glues) may be required for different pipe sizes.

• If used for transmission pipelines in camps, etc., plastic pipes must be buried – otherwise galvanized iron pipes should be used instead.

• Order ample quantities of joints and other fittings; avoid special/unusual fittings as much as possible.

• When ordering lengths of rigid pipe, take account of possible problems in transporting long lengths to the field sites: 6–metre (or 20–ft) lengths are best in most situations. However, rising main pipe for hand and power pumps is usually ordered in 3–metre lengths for easier and safer installation.

• Pipes in urban supply systems can be very large (>500 mm diameter); heavy (e.g. cast iron); fragile (asbestos cement); and frequently need heavy equipment to repair/lay.

• Traditional maintenance materials (e.g. lead, hemp), not modern equivalents, should be provided where appropriate.

Further Guidance


Aqua Plus – UNICEF

Water Manual for Refugee Situations, UNHCR (1992)


From Handpumps to Health, M. Black – UNICEF (1990)


Panels

Panel 1 – Specification of Motorized Pumpsets

**SPECIFICATION OF MOTORIZED PUMPSETS**

The following characteristics must be considered and specified when pumps are being requested/ordered:

• Delivery capacity (litre or cu.ft. per minute).

• Inlet pipe diameter.

• Outlet pipe diameter.

• Whether diesel, petrol or electric. If electric, the voltage and number of phases and whether a stand–by generator also required. If diesel/petrol, whether hand or battery starter

• The situation in which the pump is to be used: location and altitude of the site – depth and/or distance over which water is to be pumped.

• Any special considerations: e.g. salts in water which might affect certain materials in the pump.
How the pump and motor should be mounted.

Pumps coupled to an engine mounted on the same base plate are generally the most convenient. The whole assembly may be mounted on skids – if light enough to be carried – or on a trailer.

See Guide List OLGA (p.255) for further details.

Chapter 17 – Annex 5: Water and Sanitation in Urban Areas

Objective

To ensure safe water supply for affected population.

Contexts

- During conflict
- After a conflict
- After a sudden (natural) disaster
- During a severe drought

And for:

- Rural areas
- Urban areas
- Camp situations

There is also a need to differentiate emergency–caused water problems from other (chronic) problems

Preparedness

The ability to respond rapidly and appropriately depends on preparedness and access to basic data and the specifications of the existing systems.

In a deteriorating situation, anticipate any possible requirement to intervene to maintain/restore/provide WES services. Preparedness measures include:

- Establishing contacts with managers and technicians responsible for water supply and distribution, power generation and distribution, road construction and maintenance, waste disposal (water and garbage), fire department;

- Obtaining as much information as possible on existing systems, including water sources, pump stations, main pipes and distribution pipes, sewerage and waste disposal, as well as obtaining copies of plans, where possible;

- Acquiring such information also from the World Bank, major bilateral aid donors, etc. especially if they are evacuating, (original drawings and specifications for systems may be obtainable from original donors such as USAID, GTZ, ODA);

- Obtaining details of any emergency plans, local environmental practices and legislation that may affect any eventual WES interventions;

- Obtaining data on local hydrology and hydrogeology that may be vital to planning new/temporary solutions.
Coordination with all agencies working in WES programmes is particularly important to avoid duplicated sourcing of expensive individual items.

**Need for Special Expertise**

Specialist technicians should be used to assess technical needs and to coordinate technical interventions with other agencies. Levels of knowledge needed vary at each stage of the emergency response.

As soon as any possible need is recognized for UNICEF to intervene in relation to urban WES systems, mobilize an experienced technician to assess requirements, plan and initiate interventions. Ensure the continuous presence of a suitably experienced engineer and of the necessary logistic support.

**Phases of Response**

**Objective**

To ensure that everyone, especially children and women, has access to enough safe water to preserve life and that public health is not compromised by inadequate sanitation.

**Phases**

- **Emergency**: Save lives, prevent spread of disease. Exploit whatever means necessary and available to ensure households are able to obtain and store water.

- **Consolidation**: Improve access to and quantity and quality of water; ensure temporary sanitation measures. Build local capacity to operate and maintain; lay ground for rehabilitation.

- **Rehabilitation**: Restore normal production and distribution, and/or replace by alternative long-term solutions.

Focus on interventions that can be functioning quickly. Keep the phase as short as possible but, in a complex emergency, it may last until conflict ends. Emergency responses must be sustainable until normal utilities have been restored which may be some months.

Programme must work in cooperation with appropriate existing authorities. For speed of response, it may be necessary to import initial inputs.

**Once there is certain stability:**

- Restore normal public utilities.

- Repair/replace pumps, treatment units, reservoirs and pipe work.

- Assure reliable electric power supplies and/or modification to prevent damage by poor supplies.

- Reduce leaks (save water and also raise pressure in system enabling higher zones to be supplied).

- Consider possibilities for local procurement/manufacture of parts/supplies (thereby supporting local economic activity).
Assessment Actions

• Review what information is available and the extent to which it is relevant to the present emergency.

• Confirm whether contacts made remain in post.

• Ascertain which elements of the system are likely to have been damaged.

• Determine to what extent the skills, materials, equipment for the organization of the community and essential services still remain available?

Initial surveys:

Record as much as possible using standardized inventory formats. The following specific information will be needed in the context of urban water supply and sanitation:

• How many people are affected by the emergency, their locations and physical conditions.
• What essential services are affected and how.
• Who is responsible for water supply (a) pre−emergency, (b) now?
• What type(s) of waste disposal (a) exist, (b) function.
• What are the security conditions (a) at present (b) foreseeable?
• Other logistical constraints.

System specifications:

• Source(s): condition, quantity.
• Treatment: type, need for chemicals, condition.
• Pumps: locations of all pumps, types, serial numbers, condition, power supply.
• Reservoirs: storage, service, locations, conditions.
• Network: layout, pipe sizes, pipe materials, condition, recent test data.
• Sewerage: type, layout, treatment, disposal.
• Level of maintenance.
• Condition of related infrastructure (power, access roads, etc.).
• Locations of consumers, any changes in consumers.
• Essential commercial and other users such as power plants, district heating.
• Logistics of purchasing and delivering materials and equipment.

Review:

• Scale of problem: immediacy of water/sanitation related health problems. (Check situation for different population groups).

• Stability of the situation: vulnerability to further damage or increases in demand?

• Level of technology (nature of pre−existing installations)?

• Range of options available, and ease/constraints of implementation?

• Skills available/state of management (therefore, extent of technical support needed).

• Parts available, and any local manufacturing capacity (sustainability).

• Power supplies.

• Other support services.
Restoration of Normal Utilities

- Planning for this phase can start as soon as emergency inputs are sufficient to remove the threat to life.

- Technicians familiar with the original system must be sought out to describe it and to operate it. A system layout is a priority requirement. All other available records help and must be located.

- Outside consulting engineering firms may have previously planned work in the city, if so, such firms probably have important detailed knowledge of the system, which may be available in an emergency.

- Spare parts will be needed. Identify the factories that made the equipment. If they no longer function, seek alternative manufacturers/suppliers. In this case, an accurate generic specification by an experienced technician will be needed.

- Local practice may not be high technology. Initially, plan to supply existing types of equipment and materials with which local technicians will be familiar. In an emergency, there can be considerable resistance to the unfamiliar. Sources of existing technology will also be more localized and thus economic activity can be regenerated in the affected region.

- If unfamiliar resources must be imported, then training will be necessary.

- Large inputs (for a rehabilitation programme) should be supported by the continuous presence of an experienced technician, preferably the same one who made the assessment, to liaise with various partners and coordinate with other NGOs.

Interventions may require specialist technicians to:

- Assess intervention needs;
- Determine sources of equipment and materials which should be local;
- Establish business relationships with suppliers;
- Arrange transport, administrative clearance and physical delivery of goods;
- Reassess needs as the programme develops.

Full rehabilitation

The post−emergency period may provide an opportunity to plan for modernization of the city services. This will be beyond the scope of a UNICEF programme, but it should be regarded as a long−term goal and taken into account when planning any interim repairs. Opportunities may arise to:

- Replace aging pipes with new materials;
- Install improved treatment equipment;
- Optimize/reinforce pipe networks.

Working with Local/Municipal Authorities

Identifying and determining the state of functioning of the authorities responsible for water and sanitation resources and systems, and then working with them is called for, as appropriate. There may be complications in relationships between local and national authorities and a need to help strengthen/rebuild management capability.

Some authorities/planners may want to plan for long−term ‘improvements’ straight away, especially when there has been considerable destruction. Populations generally desire to return to some semblance of normality as quickly as possible.

Ensure that all concerned local authorities and other agencies understand UNICEF’s particular role and priorities. Carefully screen all requests (especially ‘shopping’ or ‘wish’ lists). Consider only those elements that coincide with UNICEF’s priorities, and explain this to the originators of the requests.
Local staff

Local staff can help to ensure that programme activities are appropriate to the local sociocultural context. Skilled local staff (both technicians and tradesmen) may not always be available and may command high salaries.

Local knowledge

Locating and mobilizing technical and management personnel familiar with (previously responsible for) the systems is important. Some municipal engineers who know the water system probably remain in post and must be consulted before starting any programme. Be aware that:

- Some individuals may not be in their correct posts – it may be possible to persuade responsible authorities to return key individuals to their normal posts; and
- Their knowledge may not be as detailed as it initially appears

Before starting a high-tech programme, reconfirm that there is no appropriate low-cost technical alternative.

Plan for short/medium-term sustainability. Options for later full-scale rehabilitation should not be compromised by short-term measures. Engineers with experience in urban infrastructure are required from the outset to help plan a phased approach.

Internally Displaced Persons

IDPs coming into urban areas are likely to congregate in the peri-urban areas where previously existing infrastructure was probably already weak/inadequate. It is important to ensure equity between local residents and displaced persons to avoid tensions.

Proceeding with Caution

Emergency WES programmes in large conurbations can be very costly ($35m total estimate for Mogadishu, $3.3m in Monrovia). Detailed planning is an essential prerequisite to such work. Commitments should not be made before plans are completed.

- Some rehabilitation interventions should not be initiated (or commitments given) unless there is reasonable assurance that resources will be available to finish the job (or at least one phase) in order not to risk leaving major works partly finished and useless.

- In many developing countries, the plant installed may be old and of diverse specifications and types, having been added to on a basis. Sourcing parts may be difficult and time consuming (nine months in Liberia).

- Continuity in funds for ongoing operation costs must be assured before making commitments or initiating repair works. Recurrent costs (salaries, vehicles) can be a burden for a long time. Consider carefully whether and under what conditions, UNICEF (or any other outside agency) should commit itself to paying, or subsidizing, such costs. Initial cost estimates are often unreliable or inflated. Where emergency is ongoing, funding should be flexible to allow for modification of the programme.

Involvement in longer term development of water distribution and waste disposal may be appropriate as part of wider urban basic services (UBS) programme, for example to extend services to previously unserved peri-urban areas. This could influence a decision to get involved at the start of the emergency programme.
In Conflict Situations

Repaired infrastructure may sometimes be damaged again, subsequently, and/or access to services may be denied to certain needy population groups.

Ensure close supervision of contractors as costs can escalate fast:

- Business interests, to gain commercial advantage, may interfere with programmes. There is a need for close supervision by an experienced contract manager, and not to rely entirely on contractors.

- It may be cost-effective to engage specialized contractors to undertake system rehabilitation, but close professional/technical supervision must be assured. Problems have arisen where UNICEF technicians did not properly supervise such contracts.

Focus on the probable need for capacity building and training:

- Most major rehabilitation programmes will require capacity/institution building components and/or technical training as well as supply inputs. UNICEF or another agency to the long-term support may waste initial investment if there is no corresponding commitment.

- Emphasize the reinforcement of coping strategies and the provision of low-technology solutions, giving more control to disaster victims and increasing their resilience should there be any recurrence.

Sanctions

Where international sanctions are in force, check if the local authority has ordered required supplies and spare parts but is unable to import them. Assistance in obtaining exemption from the sanctions committee could be cost-effective.

Technical Requirements

Common urban problems:

- Filters are often damaged and batteries stolen from generators.
- Taps left open constitutes a major problem.
- Rarely separate rainwater and sewerage systems.
- Pollution due to either excess or inadequate flows is likely.

It is therefore important to involve the population, e.g. in locating and reporting leaks.

Deliver spare parts/components when local authorities are ready and able (have the technical competence) to use them, and not before

Construction equipment for road breaking and repairs linked to water and sewerage rehabilitation is needed, as is the awareness of possible military uses of such equipment.

Urban sanitation:

- Trench latrines are most effective in the majority of situations
- Water seal (twin-pit pour-flush) latrines may be appropriate in urban areas in anticipation of eventual connection to sewer systems.
- Consider VIP latrines only in the rehabilitation phase of long-term chronic emergencies.
- Major problems rarely recognized might be the need to empty septic tanks, improve gravel pits, and/or provide advice on what to do with garbage.
• It is generally very difficult to find time and heavy equipment needed including sucking trucks for urban sanitation.

**Trucking**

The cost of trucking water is high. For example, trucking water was estimated to cost 24 times the repairs to infrastructure in Monrovia. Trucking brings no long−term benefit, but vehicles can usually be mobilized quickly as a temporary measure. There will often be an associated need for temporary storage tanks at distribution points.

**After flooding**

After flooding (as well as any situation in which urban water supply systems have been disrupted), raise water pressure in pipes and increase chlorination to reduce risks of cross−contamination from broken sewers. Ensure sanitary disposal of garbage – cordon off disposal sites and untreated sewer discharges.

**Power requirements and implications**

Rehabilitation of pumping plants requires electrical power. Running generators and mobile water treatment plants consumes large volumes of fuel, which may be difficult to import. The cost of fuel and lubricants alone for such operations in Liberia reached $800,000. per month. Consider carefully whether involvement for water supplies implies a commitment for power generation. Reconfirm that continuity of funding is available.

Generic specifications (no branded) can save money, but specification must be detailed and accurate.

**Lessons from Case Studies**

*In conflict situations, seek out experienced local technicians and, through them, available equipment and other resources:* Public utility administrations may not be functioning at all, but many previous employees may be around. Once contact is made with one, it is likely to be possible to track down others, and gradually to locate some equipment and other resources. Resources such as drilling rigs, pumps and pipework may have been hidden by their operators and/or be held by various interest groups. In Mogadishu, it was possible to hire these resources with experienced crews.

*In conflict situations, try to ensure that civil populations are not dependent for water on rival factions:* Different parts of a public utility system and associated resources (e.g. locations of wells/boreholes) may be under the control of different, sometimes opposing factions.

*In situations of anarchy, ensure that local communities can assure protection of installations:* Armed gangs may be on the lookout for anything of value, so there is a likelihood of thefts. The ability of the local (beneficiary) community to protect installations should be considered when planning assistance and, in particular, any investing in repairs and equipment in such situations.

*Promote coordination among assistance agencies to avoid the unnecessary inflation of costs:* Coordination in negotiating contracts purchasing supplies can be essential in order to avoid competition and being played off against each other, resulting in unnecessary and unreasonable inflation of prices, especially in situations of anarchy.

*Ensure equity in distribution and some cost recovery from large users:* Be aware of possible problems in ensuring equity of distribution of available water among different population groups. An agreement at the outset can stipulate that the assisting agency would provide continued support for facilities on the basis of free access up to 20 litres of water per person (per day), with a reasonable pricing structure for larger quantities. This has appeared to work with regular monitoring. The income covered recurrent costs for fuel, wages, etc.

*Promote coordination and experience exchange among all concerned organizations:* The establishment of a joint committee on water and sanitation, involving all organizations in the sector, has greatly improved the effectiveness of WES activities. Try to ensure that new agencies coming in are included and their inputs/operations complement those of others (fit this into an overall plan, where possible).
Ensure latrine/sanitation designs are suitable: Many latrines have had short life spans due to poor design, construction and maintenance. The situation can be improved with the adoption of a common design by a subcommittee of the joint sector coordination committee.

Where a population depends on a single source of water, monitor the output carefully and continuously: Retreating forces, leaving a town dependent on a single spring, may deliberately destroy boreholes and pumping installations. If no action is taken in time the fallen output may result in the closing of feeding centres, high death rates and a need for an expensive trucking operation before alternative arrangements can be made.

When lives are in immediate danger, improvise while waiting for equipment to arrive: A private borehole can be located, rehabilitated and a handpump installed while waiting for a submersible pump and generator to be brought in. In the meantime, water can be tankered in from any surface source within 50km; bladder tanks can be brought in to move water locally.

Do not raise false hope. Inform people contacted during assessments whether action is being taken or not: Local authorities (and community leaders) are often visited by representatives of many different organizations making assessments, the majority of whom do not follow up with any concrete response. This is not only discourteous but leads to disillusionment and cynicism on the part of the local authorities towards outside agencies.

Check the reliability of power supplies and protect pumping equipment from power irregularities: When there are overall shortages of power, electricity distribution managers sometimes cut one phase of the supply rather than cutting off whole areas. This can cause the windings of many 3−phase water supply booster pumps to burn out. In addition, frequent power cuts result in frequent startups of the large main supply pumps and increase the likelihood of them failing. Negotiate with the power distribution authorities to assure a more reliable supply to critical pumping stations while voltage and phase protectors are obtained and installed.

Protect pumps from debris in the system and from interruptions in flow: Pumps are often damaged by debris from repaired breakages in the supply system and by the system running dry. Inline, pre−pump strainers and low−pressure cut−out switches should be installed. It is always important to look at the reasons for failures and to try to modify systems to allow them to work under the prevailing difficult conditions, to avoid having to repeatedly bring replacement parts.

Consider all demands for water: In some more−developed cities in temperate climates, water may be required for power stations (cooling) and for central heating systems as well as for domestic and industrial use. Considerable quantities of water are also needed for flushing toilets, particularly in tower blocks.

Work with/ensure local authorities are able to protect key facilities and supplies: Facilities may be damaged by frustrated consumers and/or by looting. Transformer oil may be stolen for use as a substitute for diesel or heating oil. Public information campaigns, e.g. by radio, can help.

Try to ensure food support for key utility personnel, where necessary: Local technicians as well as utility managers (on whom the functioning of systems depend) are likely to be under considerable pressure. It can help to try to ensure that they have sufficient food for themselves and their families. Inclusion in food−for−work may be appropriate in some cases.

During a conflict, make contingency plans for the worst−case scenario: Water sources, power supplies and water distribution/storage facilities may be progressively damaged and/or fall under the control of opposing forces. The population may become dependent on fewer and fewer sources. At the same time, the population may increase by influxes of more displaced persons. While trying to sustain existing systems, assess all options and develop alternative arrangements in parallel:

- Identify and test all available sources, including, for example, shallow wells, agricultural boreholes and those serving industrial establishments;
- Prepare plans and identify equipment, supplies and transport to set up pumps/generators and localized storage/distribution facilities, and to truck water into otherwise unserved localities. (Give particular attention to ensuring reliable supplies in those localities that are likely to be the final refuge of the civilian population, i.e. those furthest from the fighting, safest from bombardment);
• Prepare plans to keep the population informed of water supply arrangements and any precautions to take;

• Prepare plans for the provision of water, probably by trucking initially, in the event that the town falls to opposing forces. (This is likely to be an unacceptable scenario to the local authorities, and should be handled delicately.)

Disused sources such as hand-dug wells may be able to be reactivated: Previously used sources/wells may have been covered over when piped water systems were installed. These may be able to be reopened to quickly provide water.

Use organizational structures unaffected by the emergency: See Aden, Yemen example on the use of mosques under examples of case studies later in this annex.

Emphasize the importance of garbage disposal and vector control and ensure that any chemicals provided are safe: Advice may be given to local authorities and community leaders on the importance of (re)establishing systems for garbage collection and vector control. Supplies of spare parts and chemicals may be needed. Take care to ensure that any toxic chemicals requested and supplied do not pose dangers for the population and cannot be used in the conflict (e.g. to make explosives).

Promote the establishment of a joint Water and Sanitation Committee: Several ministries/departments are likely to have human and material resources relevant to and involved in the maintenance of water and sanitation systems and/or the development of alternative systems. A joint committee can facilitate coordination. Seconding a suitable local engineer to the committee can be useful and allow ease of access to the relevant authorities.

Alert the international community to any indication of water being used as a weapon: Inform headquarters and (in liaison with the ICRC) any local representatives of the international community of any indications that the curtailment of water supplies – or power supplies on which water supplies depend – is being used as a weapon against civilian populations.

As soon as hostilities cease, contact local authorities and help to ensure water supplies: The authorities in power must be contacted to plan the reestablishment of services to the civilian population. This may mean trucking capacity, security for operations (desperate people will riot for water), and establishing a programme for the reestablishment of piped water. Get at least some water flowing from the sources into the system as soon as possible, even if it is temporary and insignificant compared to the needs of the population. This will allow the state or integrity of the supply, treatment and distribution system to be determined quickly. Any damage can be identified and decisions taken regarding repairs. Ensure the sustainability of alternative emergency supplies until piped water can be reestablished.

Ensure safe supplies to hospitals and other social service institutions, and measures to economize their use of water: Hospitals (including mental institutions, which are frequently ignored) are priority users of large quantities of water. However, they are usually heavily institutionalized and may be very inefficient in their practices, especially in the kitchens, laundries and public wards. Promote and support the implementation of water-saving measures, possibly including sectoral rationing, and the careful monitoring of them. Ensure that water is safe. This is most important because of the low disease-resistance of the users. Chlorination can usually be carried out in-house with little training due to the technical expertise of the staff.

Concentrate initially on measures to prevent the collapse of a system: Embark on major works only after thorough assessment and, if necessary, expertise, funds and are assured.

Where there are few experienced local technicians available, provide necessary technical assistance and on-the-job training of the public utility staff: When technicians previously responsible are not available (have fled or been killed), develop assistance interventions gradually, ensuring necessary technical assistance and training for local personnel who do not have direct experience with the specific equipment.

Consider carefully the composition of the population to be served: A large part of the present population may not have originally been urban, due to displacement. The population’s actual composition should be determined so that its needs can be accurately addressed and measures be planned to ensure the responsible use of water. If consultants are used as part of the assessment process, experienced agency staff should lead the team, or review the conclusions in detail.
Carefully plan any move into major rehabilitation or redevelopment programmes: Major rehabilitation and development in an urban environment will usually be complex, costly and require years of involvement. Exercise particular caution in situations where systems/ installations have degenerated through years of lack of maintenance, quite apart from any recent, emergency-related damage.

- Prior to the transition from relief assistance to development, it can be useful for a technical expert to be placed with the public utility authorities for a period of 6 to 12 months. A limited budget during this time will allow 'action' credibility to be maintained while an assessment is made of the entire assistance programme, including the level of cooperation of the authorities. During this period, small-scale trial programmes may be useful.

- Objectives should be achievable and consistent with the interventions and resources being provided, and the information on which the proposed programme is based should be reliable. Ongoing monitoring systems need to be established at the outset to ensure the availability of up-to-date information. This will ensure that the programme can be modified when circumstances change. Each phase of a proposed programme should have a finite scope, which will allow programme termination, if necessary. Do not get drawn into what could become open-ended assistance.

Establish formal agreements concerning responsibilities: Formal agreements with the official authorities, specifying roles, responsibilities and resources each partner will bring to the project, are essential to avoid misunderstanding at later stages.

Examples of Case Studies

- Rehabilitation of the sewerage system in Sidon, Lebanon (1980s)

  During the fighting, the subsurface sewerage concrete pipes were damaged. Household septic tanks overflowed into the system, which was backing up and flooding. Rehabilitation involved a long process of ‘rodding’ the system starting from the bottom/points of final discharge, excavating and breaking into the pipes to dig out blockages, where necessary. Breaks were left open until the system was passing again (after one month), at which time the pipes were repaired and covered and additional cesspits dug to ease the load on the system.

- Water supplies during the conflict in Aden, Yemen (1994)

  Water sources and power supplies were progressively either destroyed or damaged by the continual bombardment. With the addition of displaced people, the population of the rocky peninsula approached 500,000. With only 44 hand-dug wells, the situation became desperate. Even after the city fell, there was a period of anarchy and looting, and urgent measures were needed to avert a catastrophe.

  Most of the 44 wells were in mosques and had been covered over when piped water became generally available. The committees of the mosques proved invaluable in providing the local structure and organization so these sources could be developed quickly and the water distributed equitably. The main constraint was that this area’s mosques had latrines situated adjacent to the well. The committee had to agree to close them if they caused a potential contamination hazard. The mosque also effectively protected the pump/generator equipment from looting during the period after the city was conquered. Most of the storage and distribution tanks in areas with no water were also put under the control of the local mosque because they were the only continuing local authorities.

- Rehabilitation of Water Supply in Monrovia, Liberia (1990)

  Civil conflict in Liberia started in December 1989 with little warning. By August 1990, the capital, Monrovia, was under siege and a peacekeeping force from neighbouring West African states was sent to protect the city. They established an interim government. The population of Monrovia swelled from half a million to an estimated one million. UNICEF had development programmes in Liberia that were suspended when the conflict broke out. A programme of support in Monrovia for the Liberia water authorities (LWSC) subsequently commenced in
November 1990. Two other agencies involved in this sector were ICRC and SwedRelief.

UNICEF’s programme started with a $100,000 grant to refurbish pumping and water distribution equipment. Meanwhile, ICRC had a complementary programme to repair leaks, set up public standpipes and dig shallow wells. The UNICEF programme grew into a commitment to support LWSC with $3.3 million over one year. The conflict continued during this period.

The pumping plant could not be restarted without assuring power supplies. Only about 25 per cent of installed electricity capacity was working, and that only intermittently. At one stage, the cost of fuel and lubricants (provided by UNICEF) to run the programme reached $800,000 in one month.

Technical expertise was needed. An engineer seconded from OXFAM initially fulfilled the need.

The existing installed equipment was mostly old and from many different sources. Spare parts were hard to obtain and sourcing took up to nine months. Agencies normally providing assistance in the sector (World Bank, EU), were not present, so useful information in their data banks were not available. Valuable information eventually came to light in the files of GTZ (a previous funding agency) in Germany, but was discovered only late in the process.

UNICEF field staff found it an advantage that they had responsibility for major expenditures and could vary the programme on their own initiatives. However, this led to a large escalation of the programme without a clear objective due to the difficult nature of the problem.

The repairs to water plants eventually proved very cost-effective in relation to trucking.

**Additional Points to Remember**

- Emergency installations may end up never being replaced. Be careful not to create inequities even during the early stages of assistance.

- Uncertainty of future (continued conflict, earthquake aftershocks, etc.) may affect scale and permanence of initial responses.

- The state of political degradation has to be assessed. Careful choices may have to be made about who to deal with and whose support will be needed in order to work safely and effectively.

- In peri-urban areas, populations may always/previously have depended on water sellers. In an emergency, the sellers may still be there, with their transport, but the population has no money to pay.

- Authorities may need convincing, or require proposals to be couched in acceptable terminology, when providing assistance to displaced populations or peri-urban areas, which they do not want to see as permanent.

- Displaced rural populations may need education programmes on how to use city amenities.

- Urban systems typically favour the better off: What strategies can be adopted to ensure supplies for the more deprived localities and population groups?

- Large numbers of displaced persons often congregate in and around urban areas during emergencies: How can existing systems be configured, or what alternative arrangements be made, to meet their needs (a) in the city (b) in the peri-urban areas?

- UNICEF’s WES development strategy normally provides the best option in emergency situations: It focuses on low-cost, appropriate technologies in rural and peri-urban areas that can be operated and maintained by the communities themselves.
• Large-scale repair or rehabilitation of damaged urban water and sewerage schemes should normally be initiated only after heavy fighting has stopped: However, spot repairs to damaged treatment plants, pumping stations or pipelines may need to be carried out even during the fighting.

• Many of the key elements of WES strategy also apply in emergencies: These include the integration of water with improved sanitation and hygiene education, linkages to the control of diarrheal diseases and nutrition, community participation and training.

• Where UNICEF has been prepared to take a lead in the WES sector, funding has been forthcoming not only to enable UNICEF to respond to emergency needs but also to help reestablish or build a long-term development programme.

Contractors: Problems may be experienced due to cartels between contractors.

Drilling:

Make sure sufficient information is available if borehole drilling is to be part of a relief programme. Mistakes can be costly and aquifers can be permanently damaged by saline intrusion.

• Fast, cheap drilling methods and equipment are currently available;
• Developing new wells properly is critical.

Emergency action: There is a need to ensure water for the population while undertaking the rehabilitation of systems. Focus on the most vulnerable areas. Temporary alternative solutions are almost always needed. (Trucking is a convenient but expensive solution, and is often necessary initially as a short-term measure.)

Possible emergency options include:

• Trucking;
• Dug wells;
• Local sand-filter treatment.
• Proposals are often made to increase city supplies in general by drilling, but this may not help the large populations in the peri-urban areas or displaced populations on the fringes. Low-cost temporary wells may be a feasible approach, however in many situations, e.g. droughts, local authorities may not want to encourage IDPs to stay.

Expectations of the population and local authorities will be for the full restoration of services as soon as the emergency is over. This may not be realistic. Expectations should normally aim for progressive improvement (especially when understanding of the system is only accumulated gradually.)

Equipment and spares:

• Ensure any equipment provided comes with manuals (in a useful language) and spare parts.
• Spare parts that can be commercially valuable may be kept in agency stores until actually required.

In a conflict, care must be taken when supplying materials that could have alternative uses (such as seamless steel pipes; chlorine gas; pest/vector control poisons etc.). See that they are not abused.

Health focus:

In all situations, the main concern is for public health rather than water as such. Carefully monitor health effects in terms of water/sanitation–related diseases; design and adapt WES programmes accordingly.

In conflicts:

• The need exists to avoid further competition for water sources – separate sources and independent small distribution systems for separate localities are not dependent on power supplies.
• The most important factor is political stability – the need to combine political, management and technical/engineering approaches. Truces to implement WES can be negotiated if both sides are reliable.

• An even-handed approach is important. Assistance should be to all communities.

• Large installations almost inevitably become military target. Sophisticated systems are very vulnerable (often with few standby or back-up systems), and distinctions between military and civilian targets can be impossible

Latrines:

• Check level of groundwater before starting pit latrine programme.
• Communal pit latrines dug in toilet blocks in the city [Baku, Azerbaijan].

Pollution: Be alert to the possibility of the pollution of water supplies resulting from the destruction of industrial installations and stores, including electrical transformers, as well as from sewerage and to the importance of treatment.

Power supplies: A high-technology society may have difficulty adapting to an absence of power supplies and have a need for high-level storage.

Water quality: Realistic water quality standards may need to be adopted.

It should be recognized that quantity standards established for refugee camps generally would not be relevant in urban areas, especially in developed areas.

Chapter 17 − Annex 6: Water Assessment Checklist

1. Current water availability

   □ How many litres of water per person, per day, is currently available for:

   □ Drinking?
   □ Personal hygiene?
   □ Cooking and food preparation?
   □ Laundry?
   □ Food production?
   □ Animals?
   □ Other?

   □ Is the water for drinking and personal use safe?
   □ If not, what is the problem?

2. Actual and projected water needs

   □ What are the actual water needs of the target population to ensure a basic minimum of 7 litres?

   □ What are the institutional needs?

   □ What are the projected water needs to ensure that the target population, essential institutions and animal and food production requirements are met in the medium to long-term?

2.1 Special or priority needs
2.1.1 Special needs of children and women

- What are the special water needs of women and children?
- Is anything being done? By whom?
- What can be done, and by whom?

2.1.2 Priority institutional needs

- What are the priority water needs of hospitals, clinics and feeding centres?

2.1.3 Special needs for animals

- What are the minimum needs required to ensure survival of household livestocks?

3. Distance or time spent collecting water

- What is the average distance families have to go to collect water?
- How much time is spent collecting water?
- What are the particular problems?

4. Health, diseases, morbidity and mortality

- Are there water-related health problems?
- What are they?
- What are their statistics regarding morbidity and mortality?
- Who is responsible for dealing with such problems?
- What corrective action is needed or being taken?
- Is health and hygiene education being promoted?
- Who is doing this and with what materials, communication methods, etc.?
- What resources are available?
- What are the needs?
- What is the cost?

5. Demographic data

- What is the population affected?
- What is the population density?
- Are other population shifts or changes expected in the immediate future, and what are these?

6. Infrastructure and physical facilities (type, condition, needs)

- What is/are the water source(s)?
- Where are they located?
- What are the means of extracting the water: pumping, gravity, etc.?
- How much water is available at present?
- What is the maximum potential?
- What, if any, water treatment is done?
- How is it treated?
- Are chemicals in stock of available?
- Are there water storage facilities?
- What is the storage capacity?
- Where do people actually collect their water from?

- House connection?
- Yard tap?
- Public standpipe?
- Borehole with handpump?
- Protected dug well?
- Gravity system?
7. Operation, maintenance, management and quality control

☐ Who is responsible for operation and maintenance at various levels?

☐ Are they adequately equipped with tools and spare parts, and trained to keep the water supply fully functioning?

☐ Are there delays in repairs? How long?

☐ Are the operations and maintenance monitored?

☐ Is water quality testing being done? Who does it?

☐ What are the needs?

☐ What is the cost?

Other

8. Spare parts, equipment and other consumables

☐ Are there sufficient spare parts locally available to keep the water sources/ systems fully functioning?

☐ Where are these located?

☐ Are spare parts also available in local markets?

☐ Are there enough equipment and tools available at the local level for operation and maintenance?

☐ What are the needs?

☐ What is the cost?

9. Power supply/fuel

☐ Is there functioning electricity or another power supply?

☐ Are there frequent power failures?

☐ Is fuel locally available at an affordable cost?

☐ What are the needs?

☐ What is the cost?

10. Human resources

☐ What are the available human resources, by category and by agency/ institutions?

☐ Where are these located?

☐ Are they being paid and can they support their family on their pay?

☐ Is absenteeism a problem and why?

☐ Is there a shortfall in staff and what are the needs?

☐ Has the staff had the necessary training?

☐ What specialized training is needed?

☐ What is the cost?
11. Security of facilities and personnel

- How secure are families? How secure are they for operation and maintenance personnel?
- Is security a problem for the target population when collecting water?
- Is it possible to improve security of facilities and access?
- What are the needs?
- What are the needs?

12. Finance/budget

- What are the total resources available?
- How much does government contribute?
- How much does the community contribute?
- How much do external agencies contribute?
- How much is needed?

13. Institutional arrangements and coordination

- Which government agency is responsible for the sector?
- Are different government agencies responsible for specific subsectors? What are these?
- Which is the lead external support agency?
- What are the roles of other agencies? (ESAs, NGOs, CBOs, Private sector, etc.)

14. Other involved

- What other agencies/organizations (ESAs, NGOs, CBOs, Private sector, etc.) are involved?
- What are their roles?

15. Potential partnerships (including private sector)

- Is there potential for partnership?
- Who are they and what might be their role?

16. Road, logistics, communications

- What are the road conditions?
- What are the logistical arrangements?
- What are the communications arrangements?
- What needs to be done?

17. Policies

- Who owns the water sources or systems?
- Is there a charge for water, and how much?
- Who is responsible for operations, maintenance and management of water sources/systems?

18. Cultural, religious and behavioural

- What are the knowledge, attitudes and practices of the target population regarding water?
- Does the target population use traditional water sources?
- What types of sources are they? Where are they located?
- Are there taboos about water and its use? What are they?
- Is there a special preference of source, taste, colour of water, etc.?
- Who in the family is responsible for water collection and storage?
How is water stored in the home? Is it hygienic?

What types and sizes of containers are used for water collection and storage?


What are the practices regarding personal, food and domestic hygiene?

19. Alternative sources and solutions

What are the alternative sources and solutions?

Where are they located?

How can they be developed?

Do families obtain water from different sources for drinking, washing, cooking, etc.?

What are the implications for developing alternative sources?

What is the cost?

20. Weather patterns/seasonal considerations


How might these affect the programme?

21. Environmental concerns


Is water–quality testing being done? By whom?

How is waste water managed?

Is waste water a problem?

22. Names and locations of key people

What are the names, titles, addresses, etc. of key people, i.e. technical, administrative, other agencies, community leaders, etc.?

23. Information and data

Where can crucial decision making and planning information and data be found, i.e. water–related statistics, health–related statistics, KAP studies, physical maps, hydrological and geological maps and sector studies, plans, reports, etc.?

Chapter 18: Supporting Shelter and Domestic Needs

Rationale

Emergencies stemming from natural disasters frequently result in the widescale destruction of homes and public infrastructure. Complex emergencies involving armed conflict can also result in large–scale population displacements. Both types of emergencies create an urgent need for shelter to protect affected populations from exposure, to lessen the risk of sexual violence, and to provide families with a degree of privacy and emotional security.
Special Note: Prior to a crisis, UNICEF would not be assisting in the area of shelter and domestic needs as part of most ongoing country programmes. Therefore, providing assistance in this area is not merely a matter of expanding or accelerating ongoing work. A careful review of country level competency is required before deciding to respond. In most cases, other UN agencies and NGOs are more engaged and experienced in this sector, thus UNICEF’s role should be limited, focussing on areas where the collective impact is greatest on children. To the extent possible, shelter and domestic items should be provided as strategic components of other programmes rather than as a stand alone programme. The rapid re-establishment/ establishment of basic services in an emergency requires similar shelter and domestic inputs whether one is assisting in health centres, feeding centres, schools, or in the area of child protection such as tracing and reunification centres and psycho-social care centres. Technical advise offered in this section should be linked and applied in other sectors as appropriate.

General Aims

UNICEF’s role in meeting major shelter and domestic needs varies from one emergency situation to another. The general aims of UNICEF are to:

- Ensure the rights of families affected by emergencies to basic, appropriate shelter that provides protection from the elements, space to live and store belongings, privacy, and emotional and physical security.

- Ensure the basic warmth/comfort needs, hygiene needs, and food/water preparation needs of families affected by emergency.

- Facilitate emotional and psychological healing by restoring the community and family capacity for protection and self-support.

Basic Principles

Strategies

Ensure the rapid availability of:

- appropriate materials for repairing existing shelters and/or erecting temporary shelters;

- blankets, clothing, heating and other items needed for protection against exposure;

- soap, cooking utensils, water containers and other basic items, and hygiene and food/water preparation needs.

UNICEF interventions are based on the following principles and considerations:

Ensure access to shelter:

Access to appropriate shelter is an essential human right. Shelter should at a minimum provide protection from the elements, space to live and store belongings, privacy and emotional security. It should be designed for the smallest cohesive unit in the community – the family where possible and – in some cases for the individual. Individual family shelter is preferable to mass shelter, which is preferable to no shelter at all.

Ensure right to basic needs:

Access to items to meet basic household warmth/comfort, hygiene needs, and food/water preparation is an essential human right. At minimum, the availability of those basic household items necessary for survival must be ensured as soon as possible. Panel 1 provides a more complete list of basic household items frequently needed in an emergency.

Understand community needs:
Responses must take into account who comprises the target community and how they live. Effectiveness in meeting needs depends as much on cultural and sociological considerations as on technical ones. Prefabricated shelters, while technically sound, frequently fail because of their cultural inappropriateness. Washing, cooking, hygiene, and clothing items must be culturally appropriate as well.

Avoid evacuation:

Survivors of emergencies should not be turned into refugees. Evacuation of people from their homes, temporary camps, and resettlement elsewhere should be avoided if at all possible. Maximum effort and resources should be directed to local reconstruction efforts from the earliest possible moment.

Promote community participation:

Interventions should be designed and implemented with the community rather than for the community. Strong community involvement will help to build self-reliance and help ensure acceptance of outside assistance. Shelters should be constructed/repai red by the beneficiaries themselves, with organizational and material support from outside agencies only where needed. The capacity of stricken communities to cope and be self-sufficient should not be underestimated.

Develop procurement standards:

Relief agencies working in the same area should collaborate on procurement standards to ensure similar type and quality of household goods. Differences in goods provided and distribution methods may lead to tension among those affected by the emergency if one group receives a higher quantity or quality than another.

Link to Ongoing Assistance in Other Sectors

UNICEF cannot be expected to meet the shelter and domestic needs of all families in a crisis. Other agencies are more experienced in this area. However, providing these items as a package of interventions (e.g. along with inputs like essential drugs, school supplies, high-energy biscuits, etc.) to re-establish basic services in health, nutrition, child protection and education allows limited resources to be focussed.

Identifying Priorities

Rapid preliminary and more detailed follow-up assessments should be undertaken to acquire a basic knowledge of the target population and their shelter and domestic priorities.

Information Needed

Precise requirements are situation-specific, but information-gathering efforts should focus on the following:

- Basic facts concerning the physical environment and climate, current shelter options, and the ability to stay warm through heating and personal clothing. These collectively determine the degree of exposure to environmental conditions.

- Prevalence of exposure-related illness and death, including freezing (hypothermia), influenza, acute respiratory infection, pneumonia, and heat exhaustion.

- Factors impacting upon susceptibility to exposure-related illness, including crowding (transmission); mixture of formerly separated populations (absence of immunity); nutritional status (resistance); breastfeeding (resistance); dust and smoke lung irritants (additional causes).

- Vulnerability to environmental conditions, which depends on three major factors:

  - the physical destruction of shelter and public utility systems;
  - household losses through destruction/sale/abandonment of clothing, stoves and other personal possessions;
• disruption of trade and loss of income sources.

• Local resources availability, including human resources (construction and utility sector expertise), functioning utilities, shelter/repair/construction materials, health and personal protection items, etc.

Assessment Process

Documentary material:

The following sources provide important information:

• topographic maps (altitude);
• weather records (temperature, wind, precipitation);
• electrical and heating utility locations and blueprints;
• morbidity data (exposure-related illnesses).

Expertise required:

It is important to have persons who have field experience as well as:

• some knowledge of electrical/heating engineering;
• familiarity with design problems for the environments and climate of the emergency zone;
• knowledge of traditional shelter and heating methods;
• background in related public health issues.

Observation:

Exposure can be assessed by visual inspection. Pre-visits to similar environments and housing patterns will provide an observation baseline against which problems can be spotted. Weather observed at the time of the visit may not represent average or recent conditions; local reports must confirm them. Photographs and video are valuable to record human and shelter conditions, the environment, and heating infrastructure.

Sampling

The physical environment and climate can vary widely over small distances, primarily due to altitude and land cover. Selective sampling and location data is particularly important where there is:

• extreme climate;
• intense physical destruction;
• open-air sleeping or unsuitable ad hoc shelter;
• shortage of heating and personal protection supplies;
• high exposure mortality.

Key informants/sources:

• Draw on local weatherpersons or amateur weather watchers with recording equipment (climactic conditions);
• health workers (exposure-related illness and health hazards within shelters);
• electric and heating sector workers (resources, current capacity, facility and distribution problems);
• relief workers (upcoming relief efforts that will influence 30-day trends).

Group discussions:

Most information needed is common knowledge among residents and is not generally considered sensitive. Discuss conditions observed while walking with residents. Discussions with more selective groups are needed in the following situations:
• distressed are separated from local residents and separated groups are met individually;
• housing, clothing and fuel are on sale at very high prices and sellers and buyers must be met with separately on problems and trends;
• conflicts exist over available resources and conflicting parties are met separately.

Field-Level Actions and Strategies
Panel 1 provides the major non-food material needs of households that have been displaced or separated from their homes and personal belongings, broken down by four categories: shelter/tools needs, warmth/comfort needs, food/water preparation needs and hygiene needs. UNICEF’s role in meeting these major households needs varies from one emergency situation to another, in accordance with the urgency and extent of need and the complementary capacities of UNICEF and its partners.

In most emergencies, basic household non-food items are provided by a number of UNICEF’s major multilateral and international NGO counterparts and should only be a limited component of UNICEF’s overall response. The reimbursable procurement facilities of UNICEF should be made available to the government and partner organizations where appropriate.

Other organizations also often provide emergency shelter, and UNICEF’s resources should only be committed when the need is urgent and others are not able to act quickly enough. UNICEF support should usually be limited to temporary emergency shelter and repair in the immediate aftermath of natural disasters or conflicts. UNICEF should focus on channeling assistance to institutions rather than families. The rapid re-establishment establishment of basic services in an emergency requires shelter and domestic inputs whether one is assisting in health centres, feeding centres, schools, or in the area of child protection such as tracing and reunification centres and psycho-social care centres. UNICEF is not normally involved in the long-term reconstruction of private dwellings.

Shelter/Tool Needs
Temporary shelter
Only the necessary minimum of time, effort and resources should be committed to temporary emergency shelter; permanent reconstruction should be promoted as soon as possible. In refugee and other situations, where there is need for temporary emergency shelter, the following should be considered:

• Shelter, including communal buildings, should be constructed by beneficiaries themselves, to the extent possible, with support from outside agencies.

• Materials and design should meet minimum technical standards for local seasons.

• Materials should be able to be reused in permanent reconstruction: i.e. heavy plastic sheeting and/or tarpaulins and rope.

• Maximum use should be made of materials that can be salvaged from damaged buildings, and that would normally be used by the population. Only if adequate quantities cannot be obtained locally should material be brought into the country.

UNICEF’s Role
Access to basic, appropriate shelter should be one of the first priorities when families’ own homes have been destroyed or families have been displaced from their homes.

Where needed, UNICEF may play a role in:

• the establishment of temporary shelters, focussing on institutions that provide essential services such as schools, clinics and feeding centres,
• emergency repairs to damaged shelters,
• the provision of basic tools to encourage self-sufficiency.

Roofing should be given highest priority. Walls can usually be made of earth or other materials found on-site or locally available.

‘Temporary’ and prefabricated/relief housing should be avoided. It is rarely in fact replaced, is often very expensive, especially when comprised of imported components (absorbing resources which could be directed towards permanent reconstruction), may require special expertise to build, and is often culturally/contextually inappropriate.

The use of public buildings as temporary shelter should not be overlooked. This requires the approval of local officials and acceptance by the displaced. Minor renovations can often provide suitable low cost shelter for several families. Water and sanitation facilities are often unsuitable for multiple families. Host populations may resent long-term use of public buildings as it can restrict or halt essential activities and services such as school or community meetings. Relative cost/benefits must be carefully weighed.

Shelter repair

In the aftermath of natural disasters or conflict situations, UNICEF support may also be given to emergency repairs to damaged shelters where short-term needs are not being met by other agencies, or where low-cost inputs can help catalyse a more broad-scale repair effort. Community participation, minimum technical standards, use of locally available and appropriate materials, and priority to roofing should also be applied in this context.

Tents

Tents may be available in stockpiles and can provide temporary shelter where the improvisation of other shelter is not feasible. However, tents do deteriorate quickly in some conditions. Panel 2 provides some suggested specifications for sheeting and tents.

If free distribution of materials is considered appropriate, criteria should be carefully established to help maximum numbers of particularly needy families reestablish basic housing for themselves. In many situations, it has been found to be better, and possible, for materials to be sold at subsidized prices and/or against credit, with repayments being made into a revolving fund from which further development projects in the community are then financed. However, good knowledge of local social structures, cooperative experiences, banking, etc. is essential for this approach to succeed.

Tools

While most tools may not be essential at the onset of an emergency, providing agricultural implements or tools for repairing/maintaining a shelter may help encourage self-sufficiency. If tools are not provided directly, alternatives for making them available should be considered, i.e. a system of borrowing tools from a central repository, or selling them at subsidized prices or on credit. In all cases ensure that tools made available are culturally appropriate and familiar.

Warmth/Comfort Needs

In order to determine warmth and comfort needs, there should be a thorough understanding of the physical environment of the emergency area, including knowledge of average temperatures and precipitation levels for each season. Protection needs in windy and higher altitudes are greater than calmer and lower altitude ones. Rainy and snowy environments also pose greater dangers, influencing temperature by blocking the sun, soaking clothes, and directly lowering body temperature. Frequent or sustained precipitation can prevent full drying and warming of exposed persons. Heat can also kill, and it is more easily coped with through shade, reduced activity, and water consumption.

Where people are exposed to cold/wet conditions, especially at night, blankets, heating/cooking fuel and appropriate clothing may all be real and urgent needs. Provision might also need to be planned for seasonal changes in climate. In some cases, however, the early commitment of scarce resources to the distribution of such relief items may neither be necessary nor appropriate. Such items are not always lost in emergencies and the replacement of them may not be high among the survivors’ immediate priorities. A good needs
assessment and sound local knowledge must be the basis for action. In situations where provision must be made for warmth and comfort items, the following should be considered:

**Clothing**

Clothing must be culturally and contextually appropriate. Funds spent on shipping donated Western-style clothing to countries where such is not customary may be better spent buying clothing locally, if available, in necessary quantities. The following should be considered:

Two sets of clothing are the minimum, allowing one set to dry while the other is worn. Because of children's diarrhea incidence and general contact with dirt, three sets are recommended.

If the need is not immediate, clothes may be locally produced. Consider supplying cloth, sewing machines for tailoring cooperatives, spare parts for local textile mills, etc.

- Clothing must be available in a range of sizes, especially children's sizes.

**Heating**

Deforestation occurs rapidly when heating and/or cooking fuel is not provided, particularly in refugee camps and even among populations whose previous primary fuel source was not wood. It may be possible to replace some firewood with compressed fuel brickettes made of sawdust, rice husks or other wastes if available in sufficient quantity, although these are often more costly and require acceptance from the target population.

**Blankets**

Blankets should be durable and able to withstand getting wet. Cotton or synthetics are more appropriate than wool in tropical climates.

Locally provided blankets are more likely to be used by beneficiaries.

Blankets are versatile and may also be used as shawls (i.e. clothing).

Blankets should be given to everyone if determined to be a priority need.

Charcoal is the most healthy and labour- and energy-efficient natural source of fuel. Kerosene and other fossil fuels are also options if previously used by the population. If wood is the only fuel option, then environment-friendly methods for its acquisition, as well as reforestation programmes in conjunction with local authorities, should be encouraged.

Time and cost factors make rehabilitation of damaged systems an unlikely short-term intervention. Exceptions are:

- fuel shortages when production capacity is high;
- minor and easily repaired breakdowns;
- complete absence of alternatives.

**Food/Water Preparation Needs**

Cooking utensils, water containers and stoves may be needed for family units and/or communal kitchen facilities – especially for displaced people and those who cannot salvage their own household goods. Other agencies are often able to provide such ‘relief’ items when needed, in which case UNICEF involvement would be limited. Important considerations in meeting food/water preparation needs include:

Utensils and stoves should be of a type already used in the area – this may mean local procurement.

‘Improved’ stoves (i.e. fuel-efficient, smokeless, easily repairable, and child proof) should be introduced with caution. Local acceptability should be ensured through trials and demonstrations, before relying on widespread use.

**Plastic Jerrycans**
A variety of collapsible plastic jerrycans are now available for temporary use. They can be shipped flat in pallets, are lightweight, and can be stockpiled nearby for immediate use or quickly shipped in.

Traditional water-carrying practices should be considered in determining the most appropriate water containers. Buckets are often needed and useful and are more suitable for storing water if provided with a lid. Plastic jerry cans are very useful for carrying and storing water.

- The use of water filters or purifying equipment should be determined by the cleanliness of the water source and environmental factors. Training in their use are needed at the household level.

- Prepacked ‘family kits’ may be useful in some situations. Such supplies are needed quickly, if at all, but the need for them should not be exaggerated, nor the practical difficulties of distribution underestimated.

- Use of the lightweight emergency family cooking set may be appropriate with the possible addition of cutlery, if deliveries by air from outside the country are necessary.

- Where communal emergency facilities are intended to be a very short-term measure, supplies must be delivered quickly, or not at all. Improvisation may be called for, e.g. the use of cleaned, empty oil drums for boiling water and cooking cereals rather than investing in large (and expensive) pots which may not arrive on site before the kitchens are disbanded and family utensils are required.

Hygiene Needs

Pre-Packed Family Kits

- 2 cooking pots,
- kitchen knife,
- bowls, spoons, and cups
- suitable stove,
- lantern,
- soap and other essential hygiene supplies.

Basic hygiene items and facilities are an urgent requirement in emergency settings, especially for women. Again, other agencies are often in a position to provide such ‘relief’ items when needed, limiting UNICEF’s involvement. Important considerations in providing for basic hygiene include:

Formal provisions must be made for washing and laundry facilities, or these activities will take place haphazardly, and likely be more wasteful and less sanitary.

Washing and laundry facilities must consider cultural and religious practices, or they will likely not be used.

- Safe water is as essential for hygiene as for food preparation and drinking. It is needed for bathing and for washing clothing and eating/cooking utensils.

- Care must be taken to ensure the security of women and girls while bathing. Low, wide metal/plastic basins are often appropriate for private bathing.

- Sanitary napkins or their equivalent must be provided with consideration given to the need to wash and dry menstrual rags, often subjects of taboo. Lengths of string to enable thorough drying are useful.

- Soap should be accessible to all households. If not provided, people will generally sell a portion of their food to buy soap.

- Scissors or new razor blades are essential for birth attendants. Procedure should be established for cleaning.
• In some humid climates, ironing facilities should be available to ensure clothing is free from parasites such as the mango fly.

• The presence of local pests and insects should be accounted for and may require mousetraps, rat poison insecticide, mosquito nets, etc.

• Depending on the nature of the emergency, other necessities may include: toilet paper, combs, shaving and haircutting implements, and toothbrushes.

Further Guidance


Cuny, Frederick, ‘Cities Under Siege: Problems, Priorities and Programs’ Disasters 18(2), 1994


Intermediate Technology Bangladesh, Sanitary Protection: Addressing the Problems


Le Breton, Gus, ‘Carrying a Heavy Load’, Refugees, 89:8−11, 1992

Lorance, Bill, ‘Srebrenica Situation Existing and Plan of Action to Stabilize and Sustain Population Throughout Winter’, situation report prepared for UNHCR, 1993

Basic survival items vary according to the situation, but frequently include:

• shelter;
• one blanket per person (two or more in cold climates);
• cooking utensils – two cooking pots per household (with lids) and one wooden stirrer;
• one water container per household;
• soap;
• cooking fuel or system (may be found locally, or may have to be supplied; and matches.


UNDRO, ‘Shelter After Disaster – Guidelines for Assistance’, New York, 1982


UNHCR, Summary of Proceedings – First International Workshop on Improved Shelter Response and Environment for Refugees


Panels

Panel 1 – Common Non-Food Household Material Needs in an Emergency
Common Non–Food Household Material Needs in an Emergency

Panel 2 – Specifications for Plastic Sheeting and Tents

**SPECIFICATIONS FOR PLASTIC SHEETING AND TENTS**

**Reinforced polythene tarpaulin/groundsheet material:**

4 m wide, 50 m long (200 m² total area) in centre–folded rolls 2 m wide, 25 cm diameter, approx. 55 kg, reinforced ultraviolet–ray resistant, 0.25 mm thick (275 g/m²), plastic eyelets both sides every metre, double row of eyelets across every 5 m, colour green.

**Plastic sheeting:**

Where it is immediately and cheaply available, seamless polythene sheeting (preferably black) can also be useful although less strong than the above and without eyelets: 0.25 mm thick, 4–8 m wide, supplied in...
double-folded rolls of 100 m or more in length, approximately 1 kg/m².

**Rope:**

Essential for use with tarpaulins: minimum 1 metre rope for every square metre of tarpaulin.

**Family tents:**

12 m² tents are usually supplied. See Supply Division catalogue. Round, bell-type tents (e.g. 300 g/m² cotton or cotton/polyester canvas, total approximately 22 kg) are suitable if air-freighting is necessary and/or there are high winds, and if camp beds are not being used. 8 persons/tent. Otherwise, rectangular ridge-type tents are usually preferable (e.g. 50–880–04 made of 400 g/m² cotton or cotton/polyester canvas, total including flysheet approximately 50 kg). 6 camp beds/tent or 8 persons without camp beds.

**Hospital ward tents:**

80 m² ridge or frame tents with centre height 3.6–4.0 m and high side walls can accommodate 10 hospital beds or 40 patients without beds. Windows with mosquito nets and flaps are essential.

N.B. All tents must be supplied complete with poles (sectional steel tube), all necessary ropes/guy-lines, sufficient iron or steel pegs and pins (including spares), and mallets.

**Notes for tent suppliers:** Tent specifications are to be understood as minimum in material weight and floor space. Only quality, heavy-duty tents should be offered; white or lightly dyed (olive, green, brown). Canvas must be equally strong in warp and weft. Treatment of the canvas: salamander flame retardant, rot and water-proofing process or equivalent; chemicals used for treatment must not smell offensive. Stitching: by machine with extra strong, weatherproof thread. Ridges: reinforced with canvas or cotton tape. Hems: wide enough to accept eyelets. Eyelets: non-ferrous. Cabs and taps: strongly stitched at outer and inner ridge for upright poles. Ventilation and window openings: protected with mosquito netting. Flaps: with good overlap unless zippered. Zippered door flaps to have ties sewn on (in case zipper breaks). All entrance fasteners, zippers, clips and ties to be heavy duty and, where appropriate, non-ferrous. Anchorages for tent and flysheet every 50 cm. Guy ropes: equivalent in strength to 12 mm sisal rope and ultra-violet stabilized. Pegs for guys: 40 cm long, iron or steel. Pins for walls and groundsheet: 15 cm long, iron or steel. Poles: tubular steel (not wood or bamboo), standard sections not more than 1.5 m long. Packing: tent, poles, accessories and hardware bundled in a single packsack.)

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**Chapter 19: Developing Sanitation Systems & Approaches**

**Forenote**

This chapter must be read in context with all pertinent annexes 1–4 and chapter 17 and its annexes on water supply. A quick reference to other key chapters on nutrition, health and shelter will help establish critical linkages. As well, for specific guidance related to sanitation in cold climates please refer to ‘Out in the cold: Emergency Water Supply and Sanitation for Cold Regions’ (see essential reading references at end of this chapter).

**Rationale**

Poor environmental conditions are directly responsible for around 25 percent of all preventable ill health in the world today, with diarrhoeal diseases and acute respiratory infections heading the list. Other diseases such as malaria, schistosomiasis, other water-borne diseases and childhood infections are also strongly influenced by adverse environmental conditions (WHO 1997).

Diarrhoeal disease risks to children, pregnant women, the elderly and the frail are exceptionally high in emergency situations, especially those in densely crowded camp conditions, Children and families that are
already most disadvantaged are particularly vulnerable and predisposed to diarrhoeal diseases and infections. In such situations, rapid preventive and/or corrective action is paramount to avoid further deterioration of their health and nutritional status.

In emergencies, diarrhoeal diseases are typically related to one or more of the following: unsanitary human excreta management, poor hygiene (personal/child/food/domestic), unsafe drinking water, poor liquid- and solid- waste management and insufficient or no vector control. Although urine is relatively harmless (with exceptions to schistosomiasis in some tropical aquatic situations) the real treat to human health is from human faeces. Human faeces, including that of infants and children contain dangerous pathogens that can enter the human body via contaminated hands, food, drinking water and in some cases, worm infections, directly through the skin.

The diarrhoeal diseases of most concern in emergencies include cholera, giardiasis, salmonella, shigella, and paratyphoid and typhoid fevers. Severe diarrhoea caused by the rotavirus is a particular treat to children under two years of age. Other sanitation related diseases such as non-human Escherichia coli infections, and a variety of other diseases caused by bacteria, parasites and viruses might also be a risk. Therefore, local assessments and analyses are paramount to determine the above risks to health, as well as and the appropriate preventive/curative strategies to effectively address them.

In general, there are two modes of transmission of infectious diseases: direct contact and environmental contact. Transmission through direct contact is most effectively decreased through the promotion of safe hygiene (personal, child, domestic and food) and sanitation practices and the supply of safe drinking water. The risk of environmental transmission can be significantly reduced through protecting water sources, especially drinking water, through ensuring that food crops are not contaminated by human (and other dangerous) faeces and that adequate vector control measures are initiated.

Access to sanitation facilities is a fundamental human right that safeguards not only health but also human dignity. Therefore, in emergency situations, UNICEF (in close collaboration and coordination with other concerned organizations) will respond rapidly, within its mandate, to help meet emergency as well as longer-term sanitation, hygiene and drinking water needs of children. The extent and intensity of this response will be contingent upon the availability of sufficient human, financial and supply resources.

For specific guidance on UNICEF policy on WES for emergencies, please refer to paragraphs 54 – 60 of the Executive Board approved ‘UNICEF Strategies in Water and Environmental Sanitation’ (Document E/ICEF/1995/17, issued 13 April 1995). And for specific actions in emergency preparedness, particularly during the first 72 hours of the event, please refer to, and follow the UNICEF’s Core Corporate Commitments for WES.

General Aim

To prevent disease risks and provide sanitation privacy and security to children and women by assuring rapid response in providing sanitation and hygiene services, along with an appropriate level of hygiene education for safe behavioural practices. And to establish, maintain and sustain a hygienic environment by creating barriers between environmental health hazards and people to prevent exposure.

Other key supporting interventions needed are:

- Identification and targeting of most vulnerable groups to assess/analyse the sanitation risks they face and to determine key strategies to employ;
- Joint planning, where possible, with concerned partners for immediate critical interventions
- Effective coordination;
- Linking of initial planning, implementation and policy decisions to longer–term development;
- Strategic linkages to water, nutrition, health, shelter and education;
- Participation of target populations in decision making and actions; and,
• Periodic monitoring and analysis for further action.

**Basic Principles**

- Human rights, especially for children and women to appropriate, safe and hygienic sanitation services.

- Integrated assessment, planning and coordinated implementation to maximize synergies with key sectors such as water, nutrition, health, shelter and education.

- Adaptive programming to response rapidly to changing needs and priorities over the course of the emergency.

- Periodic/continuous monitoring and surveillance to facilitate informed decision making and adaptive programming.

- Appropriate technologies and interventions to address the prevailing socio-cultural and gender needs and the local ecology.

- Local capacity building, including other critical levels (sub-national/national), to deliver and sustain emergency sanitation and hygiene services.

- Participatory approaches to meet objectives, empower affected populations and promote their role in planning, implementing, managing and monitoring of services and activities.

- Strategic partnerships are developed to ensure holistic planning, complementarity, coordination and cooperation with government, partner UN agencies, NGO's and others.

- Emergency planning and implementation to link to long-term development.

**Identifying Priorities**

- A child-focused needs assessment is paramount at the beginning of an emergency to ascertain their critical sanitation and hygiene requirements. But also to identity potential supporting factors within their families, local community and health services regarding skills, knowledge, attitudes, practices and motivation and other essential resources for providing and sustaining of services and approached for the duration of the emergency. If regional differences exist, a single assessment may obscure critical geographic differences. A separate assessment for each affected area may be necessary and, if no reliable data exists, the use of limited sampling methodologies can provide key information quickly. See section ‘establishing a baseline’.

- Sources of information include local community and religious leaders, the health inspectorate/ministry, sanitation and water extension workers, clinics/hospitals, local NGO’s and institutions, other agencies etc.

- Assessments should be done jointly, where possible, with other concerned organizations and should ensure linkages to other critical sector assessments such as water, nutrition, health and shelter.

**Establishing a Baseline**

A baseline database should be established to facilitate strategic and appropriate decision-making regarding emergency priorities, strategies and to measure medium- to longer-term trends. This should be done, where possible, together with key stakeholders in the local community such as traditional and religious leaders, government extension workers in health, water, the environment and their parent ministries, other concerned
organizations and local institutions involved in sanitation and hygiene:

- Critical documentary information and analysis on sanitation specific to diseases, technologies, policies, institutional arrangements and capacities to sustain such services and hygiene promotional activities.
- Assessment/analysis of knowledge, attitudes, practices and skills regarding sanitation and hygiene;
- Assessment/analysis regarding the transmission routes and control measures of pertinent sanitation related diseases, as well as how these affect nutrition and health.
- Information on motivating factors regarding sanitation and hygiene;
- Demographics of the affected area/s;
- Literacy level/s;
- Pertinent gender and cultural issues and roles;
- Information on pre−emergency self−help (or other) regarding sanitation infrastructure and coping skills;
- Schematic diagramme/picture or photographs of excreta disposal technologies, as well as hand washing devices, with detailed representation of safety features or problems;
- Review of water point inventories and their status;
- Assessment of the required technical resources, as well as local availability of expertise, to fully address sanitation and hygiene in the emergency.

Reliable Data Requirements

- Human excreta disposal practices;
- Potential contamination of hands, eating/feeding utensils, drinking water and children's living environment by human faeces and other dangerous wastes;
- Ability to practice safe hygiene;
- Presence of serious pest/vermin;
- Solid and liquid wastes management/disposal capacity.

Experience and Expertise Requirements

- Familiarity with all dimensions of sanitation issues;
- Knowledge of the technology and supply requirements;
- Comprehension of cultural behaviors affecting sanitation;
- Familiarity with urban−rural differences in sanitation sector;
- Understanding of basic technology, strategies and vocabulary.

Field−Level Actions and Strategies

UNICEF's field actions for the development of sanitation systems should focus on the disposal of human excreta, vector control, and solid− and liquid− waste management/disposal.

Unfortunately, environmental sanitation is often considered only after the need for food, water, and shelter has been addressed. In all emergency situations, but especially in high−risk conditions such as camps where relocation to more appropriate sites is usually unlikely, environmental sanitation is a must in all initial
assessments and actions. Preventative sanitation measures are also intrinsic to the provision of safe food, water, and shelter and with appropriate and timely actions can substantially decrease mortality, morbidity and malnutrition.

- To maximize human health by developing and maintaining proper sanitation systems.

- To prevent the spread of diseases related to poor sanitation/hygiene and to promote the establishment of a healthy (safe) environment.

- To control and manage human waste disposal, disease–causing vectors and, solid and liquid waste

Other related problems, such as personal and domestic hygiene, water supplies, housing and food supplies, are addressed in annexes 1–5.

**Human Waste Disposal**

In order to build a barrier against fecal contamination, defecation areas and/or other types sanitation systems must be established as early as possible. The affected community should always be involved in each step (see annexes 1 and 2).

**Safe practices**

Often male and female attitudes, practices and needs vary within and across ethnic groups. Serious consideration should therefore be given to female safety and privacy, and, in general, to maximize use of services provided and to reinforce safe behavioural practices. This will necessitate, among others, that sanitation facilities be designed and placed in such a way as to maximize convenience and safety of use by women and girls and that technologies are comfortable for use by the aged and sick.

Children’s faeces are more dangerous than adult faeces due the higher concentration of pathogens. Sanitation efforts that fail to capture children’s feces are incomplete even if there is 100 percent latrine coverage for adults.

The rate of infectious diseases transmission by the faecal route is directly affected by the quantity and pathogen load of the excreta produced. Although it is impossible to control the quantity of excreta produced, it is possible to control the pathogen load of the affected population thus reducing the risk of spreading diseases from person to person and within the environment. Depending on the phase of the emergency and the resources available, it may be appropriate and possible to treat infected individuals, especially for intestinal helminthic infections. But, such decisions must always be carefully assessed by a qualified medical expert as risks to health, especially that of young children, can be a particular concern. For further guidance on this, please refer to ‘Helping the Children: A practical Handbook for complex humanitarian emergencies’ (see essential reading at end of this chapter).

The presence of faeces on the ground or close to latrines is often mistaken to mean ignorance or disregard of good sanitation. However, this is more likely to be related to poor technology choice and/or maintenance, inadequate attention given to gender or cultural needs or another inhibiting factor. Oversight and maintenance are often more needed than health education, at least in the initial short-term response phase of emergencies. But, this does not negate the critical importance of providing hygiene education at the earliest possible opportunity.

Efforts to improve sanitation, particularly excreta management/disposal, will suffer if no local authority and/or community organizational arrangements are made responsible for the provision of services, legal ramifications, maintenance of facilities and hygiene promotion. Responsibility may rest with government, community leaders, individual families, CBOs or NGOs, or a combination of the above.
Facilities

Construction of facilities should consider the following elements:

- Cultural, gender, small child and elderly needs,
- Privacy, safety (especially for women and girls) and convenience,
- Ease of use (pedestal or squat plate) and maintenance,
- Soil/flooding conditions,
- Location (distance from users, from water sources etc.),
- Flies/odors,
- Length of use,
- Cost effectiveness.

There are four basic types of excreta disposal systems:

- Dry or wet
- On- or off-site.

Wet systems, particularly unlined pit latrines and broken sewer systems pose a grave risk to groundwater (and possibly food crops) contamination if they are built close to drinking water sources (such as wells or boreholes) or in areas where shallow water tables exist.

Dry-lined pits or above ground sealed chambers (where shallow water tables exist) are much safer and are more appropriate to creating barriers against contamination. As mentioned earlier, urine does not pose a health risk if it is not directly handled and if it is not dumped directly into water courses/sources. An appropriate way to handle urine is to divert it at source through urinals for men and diverter latrine seats for women. In this way, urine does not come in contact with pathogen--laden faeces. An appropriate use of urine is a fertilizer for trees or plants, therefore providing a good drain to these areas could help provide firewood, building poles or food (see Annex on ecological sanitation). Another advantage of diverting urine from faeces is fly and smell reduction.

Human faeces, however, poses a major health risk if it is not appropriately contained from contaminating water, fields, hands, food etc., and if it is not treated to make it pathogen-- and helminth-- free before disposing it into the environment. Faeces mixed with urine, in dark warm pits or containers, create ideal conditions for multiplying and sustaining harmful pathogens. The quicker faeces are dehydrated, the faster harmful pathogens can be killed off. In summary, if faeces are kept as dry as possible and not allowed to mix with urine or other liquids – the risk of spreading harmful pathogens in an emergency situation can be significantly reduced.

Social acceptance is paramount to encourage use and maintenance of sanitation facilities, and is more important than formal standards for facility design.

An understanding of the key differences between commonly used sanitation facilities and open--air/field defecation is important when deciding the most appropriate type of system to use/rehabilitate in a given emergency situation. When deciding which type to use, the critical difference is whether the facility will be shared (communal) or private (family).

Communal facilities are generally more difficult to maintain, unless there is a responsible and well--organised arrangement for this. If they are not well maintained, they can pose a health treat to users and others in the vicinity.

Family facilities are generally easier to maintain and family members can undertake this, but they can be more costly and take longer to build or rehabilitate.

Open--air/field defecation potentially threatens everyone, unless there is plenty of space to appropriately fence it off and for rotation of defection areas. Other key factors that affect this approach are ambient temperature, humidity and soil conditions. Therefore, this type of temporary sanitation arrangement is best done if the ground is dry and sandy and if the climate is dry and/or hot. Wet and humid conditions are not suitable for this approach. Defecation areas should not be located too near dwellings, food centres or medical facilities. A minimum (possibly 30 metres) and/or a maximum distance from these areas should be (and is best) determined locally and adhered to.
**Piped sewage facility** may be appropriate in certain urban type situations where there are adequate technical resources, infrastructure and a sufficient and reliable water supply. But this option should be carefully assessed, especially regarding cost benefits and long-term sustainability. And where such systems are considered appropriate, they should be investigated for safety and examined by a qualified engineer especially regarding the treatment or discharge points in order to minimize risks to human health and effluent pollution of water supplies and/or food crops.

It is essential in all sanitation programmes to provide hand-washing facilities (along with soap or ash) as close as possible to latrines/toilets to encourage safe immediate hand-washing practices after defecation. It is also advised that hygiene and environmental sanitation education be given, at the earliest opportunity, to the affected population to reinforce safe behavioural practices, and for maintenance of facilities and living environment.

**Objectives for Human Waste Disposal**

- Prevent the spread of human faeces into the surrounding environment;
- Provide tools for and/or defecation facilities to the affected population;
- Foster community based structures to manage excreta disposal issues.

**Soil conditions**

Soil conditions affect sanitation solutions. For example:

- Pit latrines are difficult to dig in rocky ground and therefore may need to be adapted to an over-the-ground sealed chamber, instead.
- Pit latrine building in sandy soil demands special measures to prevent the sidewalls from collapsing (again, an over-the-ground chamber may be a better choice).
- Pit latrines in wet soils (shallow aquifers) pose a treat to water pollution and therefore may also have to be constructed above ground.
- Pit latrines built in impervious clay soil may exclude any system that uses water or requires seepage.
- Soil conditions can vary over short distances, as well, seasonal differences may considerably affect design criteria, and therefore these must be assessed and taken into account.

**Assessing excreta disposal**

- The type/s of excreta disposal technology/s used in the emergency zone?
- Are hand washing facilities located near defecation areas?
- What are the safe critical and also convenient distances of the sanitation facilities to: user’s shelters/homes, to feeding centres/schools/clinics, to hand-washing facilities, to drinking water supplies. How safe and private are facilities for use by women and girls? These safety and convenience issues must be determined locally and in context of security/crime and soil, hydrogeological and climatic conditions, as well as user needs.

**Varying Conditions**

If the watertable is high, or flooding is likely, excreta must be contained in watertight or raised container systems. If floodwater enters defecation sites, large areas could become contaminated. Wet sanitation systems should be avoided where the water supply is inadequate or intermittent – wet systems are generally more expensive than dry systems.

- What soil/hydrogeological conditions exist in the emergency zone?
- What are the defecation practices of children, females and males?
• What are the hygiene and safety problems in and/or around latrines or other enclosed defecation sites?

• What are the reasons (socio-cultural, technical etc.) for unsafe excreta disposal practices?

• Who are the responsible authorities, and what are the potentials for organizing local control?

• What are the expected waste disposal needs and trends over the next 1–3 months?

Immediate interventions (see sanitation annexes for more details)

Pollution of the environment by excreta cannot be stopped without immediate excreta disposal measures. The ranges of choices are therefore limited during the early stages of an emergency. Temporary systems can be improved/replaced later. The following physical and management options should carefully planned for:

• The provision and use of latrine construction kits

• Provision of soap or ash for hand-washing and personal hygiene

• Provision of facilities that are private, safe for female use and convenient

• Provision of portable potties (adults and children), especially for night-time use of small children and the sick

• Trench latrines

• Controlled surface defecation

• Simple pits latrines

• Creation of a sanitation and hygiene committee/s

• Key actions, roles and responsibilities for users, local NGO’s and government institutions

• Key policy, planning, management and coordination issues

• Creation of a sanitation/hygiene store for equipment and supplies

• Basic training and use of participatory education tools and techniques

Medium to long-term interventions (see sanitation annexes for more details)

Consideration should be given to soil conditions, water availability, cultural preferences, female safety and number of users, construction materials and drainage. Options include:

• Ventilated pit latrines
• Pour-flush latrines
• Ecological/composting dry-sanitation latrines (urine diversion and/or urinals)
• Aqua-privies
• Septic tanks
• Small bore sewer systems
• Double pit latrines
• Burial of faeces with soil

Vector Control

Emergencies often create environments that favour the proliferation of disease-carrying insects and rodents. Crowded camp conditions increase the risk of exposure to vector and disease transmission. But first determine if there is a vector problem and analyse the problem/s. Previous vector control operations, if they existed, may have been interrupted by the emergency. The effects of arthropod-borne diseases and their
vectors range from mild illness to death. Their impact ranges from injury and disease in humans to crop losses, infestations of stored products and destruction of wooden structures.

The presence of vectors

Vectors may be observed or reported by others. The presence of vectors does not by itself indicate a health problem. Confirmation of health problems can be made within a health assessment (disease incidence) and food assessment (spoilage, infestation).

A survey of habitats and conditions in which vectors multiply can reveal the major health risks. Key areas to examine include refuse dumps, stagnant water bodies, waste water drainage and crowded living conditions.

Vector control constraints

Current vector control should be assessed with new efforts that build on existing practices. Many constraints may preclude an organized and/or effective vector control response.

Vector control falls into two types: physical and chemical. Insecticides should be used sparingly and certainly not on a routine basis. In the initial stages of an emergency, physical and chemical means of vector control may be urgently required (see annex 3). However, in all circumstances, seek advice from a specialist regarding safe use of chemicals, particularly in environments where children could be at risk.

Objectives for Vector Control

- Eliminate breeding places by maintaining a clean environment.
- Reduce transmission of communicable diseases by destroying or containing vectors.
- Prevent vector access to human, feeding and breeding sites.
- Reduce losses and contamination of food stocks by rodents.
- Foster community-based structures to manage vector/pest problems.

Immediate Interventions:

(Rodent Control)

- Rodent surveys
- Eliminate their food
- Eliminate their water
- Eliminate harborage
- Trap rodents
- Chemical control
- Rodent bait stations
- Disposal of dead rodents (Arthropod Control)
- Personal grooming and hygiene measures
- Clothing cleansing
- Preventive medical measures

Medium to long-term interventions

- Establishment of regular control measures
- Formal and informal education programmes
- Training of local authorities and affected populations in control measures

Solid-waste disposal/management

These include paper/food waste/plastics/glass/metals/medical waste/ashes/dead animals/animal and fish garbage/manure. In emergency situations, poor solid waste management/disposal can result in disease from vectors (see annex 4).

If pre-wrapped rations are used during the early stages of an emergency, solid-waste disposal will likely be a serious problem. The longer the emergency and the more densely populated the settlements are, the greater the risks will be unless immediate action is taken to plan for and control solid waste.
Solid waste resulting from vaccinations and intravenous (IV) medical treatment can be very dangerous and can accumulate rapidly. Such wastes must be safely disposed of. It is strongly advised to get expert advice on the various types of medical wastes being generated and the risks they pose to children and others who may come in contact with them.

Assessing Vector Control

- Which vectors are present in the area?
- What conditions are present that favour vectors?
- What vector control measures are currently being used?
- What constraints exist to control vector–related problems?
- What is the expected vector–related problems in the next 1–3 months?

In some cases free–range chickens, goats and pigs can help control garbage, provided that they are not allowed to come in contact with food/water/cooking or child feeding utensils or within small children’s crawling/play areas. Dogs tend to spread waste.

Dead humans and animals

Corpses on the surface or in water may pose health hazards mandating immediate action. Bodies are likely to transmit typhus and plague. Animal corpses are as dangerous a health risk as human ones are.

Corpses in water or in mass graves almost always indicate a society undergoing mass social trauma. The willfulness behind the refusal to burial or the use of corpses to poison water supplies is an early warning indicator of enduring political violence. Where such conditions exist, an assessment by an environmental health specialist and trauma assessment expert is advisable.

Cremation and burial are hygienic methods. If fuel shortages prompt a shift from burning to burial no action is needed, unless burial is done improperly.

Solid–Waste Management

Three basic types of solid waste management can be used.

Storage and frequent collection: Containers should be a minimum capacity of 50 litres with secure lids on top and drainage holes at bottom. One container per 10 families should be provided within convenient useable distance from dwellings.

Collection: Collection should be on a regular basis, preferably daily, including for medical and food wastes. Transport can be by animal or cart or any other traditional or convenient method.

Disposal and treatment: Medical wastes should be incinerated without delay. Incineration should be done far from dwellings (with restricted access). It is always good practice to bury incinerated waste, as temperature may not have been high enough to kill all pathogens. Solid waste should be buried or burned.

Immediate interventions

- Burial in pits or trenches (at least 30 m from any water source and 10m from kitchens)
- Incineration (open, cross–trench, stack, or inclined plane)
- Collecting and removal of rubbish waste from hospitals/clinics, markets and shelters/homes.

Objectives for Solid–Waste Disposal

- Ensure facilities exist for collection and removal of solid waste to a safe distance from human habitation and medical and food facilities;
- Arrange for the dignified burial of human remains and the hygienic burial of animal remains;
- Foster community–based structures to manage solid–waste disposal.
Medium- to long-term interventions

- Develop monitoring systems for inspection/control
- Establish income-generating production and/or supply line
- Establish government authority and private sector capacity for waste management/disposal

Liquid-Waste Disposal

Constraints to management of liquid wastes may be due to lack of a perceived problem or to limited resources or capacity. Management of liquid waste will depend on the locality, physical conditions (topography, soil, and water table) types of waste and prior practices.

Liquid wastes can accumulate quickly, particularly if laundry/showering/washing facilities are being used. Wastewater generated from washing, bathing and food preparation should be drained away quickly from the site and preferably used to irrigate trees, plants or food crops. Otherwise ensure that appropriate soak pits are developed and maintained. If this is not possible, the wastewater should channel to a suitable water drain or evaporation bed.

Stagnant water should be removed and/or treated quickly, as it rapidly creates odours and provides breeding grounds for insects, especially mosquitoes and diseases such as cholera.

Assessing liquid–waste disposal

- Is stagnant/waste water present in and around the emergency zone?
- What are the constraints to removal of stagnant/waste water?
- Who is responsible for liquid–waste management?
- What are the expected trends in liquid–waste problems over the next 1–3 months?

High priority should be given to drainage around water collection and distribution points. Wastewater can be used for vegetable and fruit–tree irrigation. Shelters, toilets and washing areas should also receive priority. In no case should wastewater be channeled into latrines. In some cases, treatment of waster water with chlorine may be required. Drainage water may be channeled to animal troughs where appropriate.

Assessing Solid–Waste Disposal

- What are the current methods used to dispose of solid wastes?
- Are solid wastes visible within shelter, housing, medical or food handling sites?
- How are dead humans and animals buried/disposed of?
- Are human and animal corpses present?
- What are the reasons for poor solid–waste–disposal practices?
- What are the expected solid–waste disposal trends over the next 1–3 months?

Immediate Interventions

- Soakage pits
- Soakage trenches
- Evaporation beds
- Chlorination
- Drainage of roads in and around emergency zone

Objectives for Liquid–waste Disposal

- Ensure disposal of liquid wastes from kitchen, bathing, medical centres and water points.
- Provide proper drainage of accumulated water.
- Quickly remove cause of smells and the breeding sites of insects.
- Foster community–based solutions for management of liquid wastes.
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Chapter 19 – Annex 1: Types of Latrine

Objective

To rapidly respond to emergency sanitation needs by providing appropriate latrine technology services to address pertinent cultural, gender, resource and environmental conditions.

Note: This annex provides brief descriptions of different types of latrines. The circumstances in which it might be necessary and appropriate to provide latrines are reviewed in Annex 2. More details of the various types can be found in Further Guidance, at end of Chapter 19.

Shallow/Straddle Trench Latrines

These are cheap and are easy to dig in most locations using handtools such as picks and shovels and are a good immediate emergency measure. However, because of their shallow design, and in cases where space is a problem and user numbers are high, they fill up within a few days. Therefore contingency planning for alternatives is a prerequisite.

- Shallow trenches are usually 30 cm wide and 90–150 cm deep.
- For every 100 people, a trench of 3–5 m length is recommended.
- Latrine users, to cover each stool they pass, should use excavated soil from trench making.
- Standing boards should be placed along the sides of the trench for sure footing and to prevent the trench sides caving in
- When the trench is filled to within 30 cm of the top, use should be discontinued and the trench backfilled with soil and compacted. The site should be marked and dated and a new trench (or improved system) used.
- Construct separate urinals for men, this will reduce the concentration of urine/faeces mix in the trench, speed up the drying of faeces and will considerably reduce smells.
- Construct hand washing facilities, these can be simple such as a 200 litre drum with a self–closing tap. Always promote the use of soap or ash in hand washing to effectively remove harmful pathogens on hands from anal cleansing or handling of faeces or contaminated surfaces. And always avoid the promoting of communal hand washing, in a common basin or container, as this does more to spread disease than to prevent it.

Privacy and safety is critical to women and adolescent girls. To enhance privacy, ensure that a non–see through fence, or cubicles, is made from whatever suitable material is available. Canvas, plastic or G.I. sheeting, plywood or grass mats are all good fencing materials. Design for ease of maintenance and cleaning is also important to encourage use at all times. Therefore, where possible, provide squat plated or pedestal seats that are easy to keep clean. Anal cleaning materials should be provided. It may be necessary for special sanitation squads to inspect trenches daily and to organize the filling in and replacement of them. Where possible, simple platforms might be placed over each trench: They should be easy to clean and to move on to the next, replacement trench.

Important Note: Always provide a crash campaign on hygiene education to promote hand washing after
defecation or handling of children’s stools (faeces), before handling food, drinking, eating or child feeding utensils, and before eating. As well, encourage the covering of each stool movement with a little ash, soil or lime to reduce fly breeding, smells, and to encourage rapid breakdown of excreta. It is paramount to, educate child caretakers about the dangers of handling children’s faeces, encourage them to safely dispose of all faeces in a latrine or bury them. And very important, is to encourage them to always wash their hands after handling child faeces.

**Deep Trench Latrines**

These last longer than shallow trenches and can also be dug by hand, but digging takes more time unless mechanical excavators can be quickly mobilized. Each trench can last for several weeks. However, it is crucial that an assessment of risks to ground water contamination is done prior to promoting such trenches. As with shallow trenches, always address privacy, maintenance and hygiene issues.

- Deep trench latrines are typically 1.5–2.5 m deep and 75–90 cm wide.
- For every 100 people, 3.5 m of length is recommended.
- Soil should be piled up and used to cover each stool movement, as for shallow trenches.
- The sides of the trench should be shored up if there is any danger of collapse.
- When the trench is filled to within 30 cm of the top, use should be discontinued and the trench backfilled with soil and compacted. The site should be marked and dated and a new trench (or improved system) used.
- Construct separate urinals for men, this will reduce the concentration of urine/faeces mix in the trench, speed up the drying of faeces and will considerably reduce smells.
- Construct hand washing facilities, these can be simple such as a 200litre drum with a self-closing tap. Always promote the use of soap or ash in hand washing to effectively remove harmful pathogens on hands from anal cleansing or handling of faeces or contaminated surfaces. And always avoid the promoting of communal hand washing, in a common basin or container, as this does more to spread disease than to prevent it.

**Pit Latrines**

The most common excreta disposal system, in many parts of the world, is the individual family pit latrine. It consists of a squatting plate/slab (sometimes fitted with a pedestal seat for comfort and ease) and fitted above a hole in the ground with a superstructure for privacy. A seat/squat hole cover in these types of pits helps reduce fly breeding and smells.

Individual families can dig the pit and build the superstructure. If used by only one family, these latrines are usually well maintained. Pit latrines can also be used in clusters as communal facilities, but maintenance and cleaning arrangements must be assured.

- The pit is typically about 1 m across and 2 m deep.
- The rim of the pit should be raised about 15 cm above ground level. And a drain–off ditch dug around the superstructure to divert any rainwater run–off.
- In unconsolidated soil conditions, the sides of the pit should be reinforced, perhaps to a depth of 1 m below ground level to prevent collapse (old open–ended oil drums or concrete rings make good liners in sandy and unconsolidated soils)
- Where cement is hard to get, a light wooden squatting plate or wooden lattice, although harder to clean, may be more practical.
• When the pit is three quarters full, it should be back−filled with soil and closed off. The superstructure and squatting plate should then be moved to a new pit.

As with trenched latrines, always address privacy, maintenance and hygiene issues.

‘VIP’ (ventilated improved pit) Latrines

The VIP version should be built whenever possible. These do not necessarily have to be built of solid materials such as bricks and concrete blocks; lighter materials can also be used such as mud bricks, straw mat walls, timber or CI sheeting. The main difference between the ordinary pit latrine and the VIP is that the VIP has a ventpipe (chimney) fitted to draft−off smell, and this pipe is also fitted with a fine screen to trap and kill flies. (See Panel 3):

• The vent pipe is typically 15 cm in dia. ventilated improved version meter, about 2 m high, painted black and placed on the sunny side of the latrine to accelerate upward drafts to maximum odour and insect control. The top of the pipe must be fitted with an insect−proof gauze screen to prevent flies escaping from the dark pit.

• A lid should therefore not be used to cover the squat hole or seat, as this would impede the airflow.

As with trenched latrines, always address privacy, maintenance and hygiene issues.

Borehole Latrines

These latrines are bored/drilled with a hand auger or mechanical drill and require a smaller squat slab than a normal pit latrine. They can quickly be constructed as family units if augers are available. However, the side walls are liable to fouling, they tend to be smellier than vented systems, and the risk of ground water contamination is greater because of their depth. Therefore an assessment should be carried out on risks to groundwater contamination, prior to deciding to use this technology.

• The borehole of this type of latrine is typically 35−45 cm in diameter and may be as deep as 7 m.

• Pipe grips may be needed to turn hand−operated augers, and a tripod and block and tackle for guiding and withdrawing the auger (see Panel 4).

• A fly−proof seat structure should be provided (this also reduces fouling and smells).

Bucket Latrines

Bucket latrines have a reputation of being dirty and smelly. However, if used appropriately, fitted into a wider collection and disposal system and if training in maintenance and hygiene education given, they can be very effective, convenient and private. This type of system does require, however, daily maintenance and cleaning. Buckets need to be emptied into a larger collection tank or system daily, if this is not done it may discourage their use. Organizers should mobilize families to do most of this emptying work. Bucket systems have a clear advantage of being very mobile, thus enabling privacy for use in safe places, especially for women and girls. They are especially useful at night for home/shelter use, especially in dark or unsafe camp environments or for use by the sick and disabled. Buckets can also be fitted with simple easy−to−clean plastic seats and lids. When promoting this type of system it is advisable to also promote the use of a separate bucket for urinating. This will greatly reduce smells, sloppy liquids and will reduce the risk of spreading of harmful pathogens in the environment. It will also enable the use of urine for tree or plant fertilization.

Always address privacy, maintenance and hygiene issues
Ecological or Composting Latrines

These latrines are designed to render excreta harmless by accelerating the kill–off of harmful pathogens within approximately six months, and also produce fertilizer. See Panel 5 for an example of this type of latrine suitable for a family of 5–10 people.

The major difference between this type of latrine and others pit latrines is that urine and faeces are never mixed together. A urine diverter facilitates draining of urine away from faeces, thus accelerating dehydration of the faeces and speeding pathogen kill–off. Separate urinals can also be fitted for male use. The diverted urine can then be collected in a separate container for use as fertilizer or for disposal in a safe place. As explained earlier in Chapter 5, this approach is ecological, it also helps reduce the risk of spreading harmful pathogens in the environment, and it provides potential for fertilizer and soil conditioner production, as well as income generation. Unlike wet pit latrines, these dry shallow–pits and/or surface chambers (for containing faeces) greatly reduce the risks of contaminating ground water sources.

- After each defecation, ashes or soil or lime should be sprinkled over the faeces to accelerate drying, reduce fly breeding and smells.

- Once the faeces chamber or shallow pit is full, it should be sealed off and the contents left to continue to decompose for a period of approximately six months. If the system is fitted with two chambers or pits, the second one can then be used; otherwise the superstructure can be moved to a new pit/chamber. Within approximately six months (in most warm climates) the contents of the sealed off–chamber/pit should be free of all harmful pathogens and helmints. The contents may then be used as a soil conditioner on croplands or for tree production, or be buried in a pit.

- Like other latrines, these latrines can be built from cheap locally available materials.

- Always ensure that hand washing facilities are provided close to the latrine.

Water–Seal Latrines

Water seal (‘pour–flush’) latrines are relatively cheap, simple to build, but require a permeable soil effluent soakaway, as well as a reliable supply of water. In areas with impermeable soil such as clay, it may not be possible to use a soakage pit. Should this be the case, use a pipe to divert the effluent to a place where it can be safely disposed/managed? Effluent can be treated fairly simply and cheaply using stabilization (oxidization) ponds – in which the wastes are broken down and the harmful pathogens rendered safe by natural processes. However, as with all wet latrine systems, it is advisable to assess the risks to groundwater contamination prior to promoting this type of technology.

These pit latrines can also be modified to water–seal latrines where soil conditions allow (see Panel 6). The water seal can be made with a U–pipe fitted to the squatting pan or seat. Hand flushing typically takes approximately 1–3 litres of water per use and therefore daily quantities must be planned for.

- A large water container with a 2–3litre dipper should be kept close to the latrine for hand flushing.

- This type of system is preferred in cultures where water is used for anal cleaning and where the people are used to having had a flush toilet system.

- This system is, however, not suitable where paper, stones, corncobs or other solid materials are used for anal cleaning – due to their risk of blocking the system.

- Ponds are particularly effective in hot climates, as the rate of treatment and killing–off of pathogens increases with higher temperature.

- Required large space for pond (size depends on population and mean temperature). A rough guide is that approximately 1 sq.m of pond is required per person.
• Water seal latrines must be properly constructed managed and maintained, and ponds must be securely fenced off from the public.

• Always ensure that hand washing facilities are provided close to the latrine.

**Aqua Privies**

Aqua privies consist of a squatting plate or seat above a small septic tank from which effluent drains to an adjacent soakage pit (see Panel 7).

• These systems normally require a minimum size water tank reservoir of 1 cub.m capacity (1,000 litres).

• Flushing for each defecation takes approximately 5 litres.

• The water reservoir needs frequent filling.

• Always ensure that hand washing facilities are provided close to the aqua privy.

• Aqua privies are less prone to blockages when compared with water−seal latrines. But, this type of system is not recommended where solid materials are used for anal cleaning, or where water is scarce, as the system requires a relatively large supply to operate properly.

**Emergency Sanitation Units**

The OXFAM sanitation unit is an example of a complete, packaged system ‘ready−to−assemble’ on−site. These units can be air freighted into emergency situations, if necessary. Each unit comprises 20 squatting plates, two flexible tanks made of nylon−reinforced butyl rubber for sewage treatment, and all necessary pipes and fittings. An experienced team of two people can typically assemble the complete unit in about 1−2 days.

• This system is suitable for use most soil conditions, as the unit is self−contained, but does require a soak pit or treatment pool.

• One unit can serve up to 1,000 persons per day.

• One unit typically requires about 3,000 litres of water a day at full design capacity (water must not be saline).

• This system is not suitable for communities who use solids (stones, corncobs, etc.) for anal cleaning and has therefore been used widely in Asia but little in Africa to date.

The main disadvantages are cost, problems of unfamiliarity, and the quantity of water required. A reliable operator is essential. The effluent contains as many bacteria as raw sewage and must, therefore, be carefully treated before being released into the environment.

The descriptions provided in this annex are adapted from the *UNHCR Handbook for Emergencies*.

**Panels**

**Panel 1 – Shallow Trench Latrine**
Panel 2 – Cover for Deep Trench Latrine

COVER FOR DEEP TRENCH LATRINE

Panel 3 – Pit Latrines

PIT LATRINES
Panel 4 − Sinking a Deep Bored−Hole Latrine

SINKING A DEEP BORED−HOLE LATRINE

Panel 5 − Double−Bin Composting Latrine (enclosure not shown)

DOUBLE−BIN COMPOSTING LATRINE
(enclosure not shown)
Panel 6 − Water Seal (Pour−Flush) Latrine

WATER SEAL (POUR−FLUSH) LATRINE

- Slope roof so that rain runs off away from pit.
- Ventilation.
- Door.
- Water seal - may be cast in one unit with squating slab.
- Reinforced and impervious.
- Pit (filled with stones).
Chapter 19 – Annex 2: Disposing of Excreta

Objective

To ensure that appropriate socio-cultural and technical arrangements are made for the safe management/disposal of human excreta. And those create effective barriers to disease and also minimize risk to contaminating the environment and water supplies.

Priorities and Methods

In emergencies the sanitary disposal of excreta is likely to pose particular and urgent problems in two kinds of situations:

- In urban situations where damage or disruptions of services (sewerage, septic or other) have taken place.
- In camps/settlements where displaced persons/refugees are collected in crowded camped conditions (either rural or urban settings).

In most cases, temporary arrangements will have to be made rapidly to reduce immediate health risks. Panel 1 suggests the phases of action that might be appropriate. Panel 2 summarizes some of the dangers of inadequate arrangements.

A timely response is of the essence, days or weeks cannot be allowed to pass while waiting for expert advice or construction to be completed or material to arrive! Interim, emergency arrangements should be made with plans to improved or replaced, as soon as possible, with better arrangements.

Uncontrolled surface defecation – or the same in water sources (sea/rivers/lakes), is a major health hazard. But these risks can be significantly reduced if immediate and temporary arrangements are made to initially control where people defecate. Follow up possibilities for the successful establishment and operation of workable sanitation systems will depend on several factors, such as:
• The physical characteristics of the area, including geology, rainfall, drainage and the availability of water;

• The socio-cultural, gender and age group considerations and needs, including previous knowledge, attitudes and practices, and

• Spatial requirements, availability of materials, equipment and expertise available for the emergency response.

The appropriateness of the technology (cost, construction techniques, maintenance etc.) is also major considerations. Failure to take proper account of any of these aspects could easily result in the system not being used and/or breaking down and rapidly becoming a health hazard.

**Note:** What can be done during the emergency phase depends on the previous levels of services and facilities, and local knowledge, attitudes and practices. It is not realistic to expect that habits can suddenly be improved, with a crash courses on hygiene and sanitation, especially in the middle of an emergency response. Modifications or adjustments of traditional practices can, however, are sought through simultaneous practical measures and public education.

**Further Guidance & References**

(see Chapter 19)

**Panels**

**Panel 1 – Phased Actions to Reduce Health Hazards**

<table>
<thead>
<tr>
<th>PHASED ACTIONS TO REDUCE HEALTH HAZARDS</th>
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<tr>
<td>Where municipal systems are disrupted/inadequate:</td>
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<tr>
<td>1. Immediately establish temporary alternative arrangements – probably communal trench latrines and/or chemical toilets.</td>
</tr>
<tr>
<td>2. Disinfect the immediate environment of any damaged facilities, if there is risk of contaminating water or food.</td>
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<tr>
<td>3. Repair/replace facilities as quickly as possible.</td>
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<tr>
<td>4. Where insufficient water is available for normal system operation, prevent further use of blocked sewage pipelines until cleared, and institute public information with advice on most efficient use of water for flushing toilets.</td>
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<tr>
<td>5. Isolate, and disinfect or cordon–off any areas where untreated sewage discharges have/are occurring.</td>
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**Arrangements in non–urban areas:**

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<th>Arrangements in non–urban areas:</th>
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<tr>
<td>1. Consult with community leaders, local health and sanitation personnel and social mobilization personnel to determine what arrangements are best to reduce health risks.</td>
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<tr>
<td>2. Immediately establish arrangements to control/localize defecation – probably in designated, enclosed areas (unless sufficient latrines already exist).</td>
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<tr>
<td>3. Organize and establish maintenance of latrines/defecation areas:</td>
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</tbody>
</table>
• Trench latrines may be needed initially, but, where feasible, individual family latrines are usually much better.

• Ensure that latrines are suitable for children and that they can be used safely at night, and that appropriate anal cleaning materials and hand-washing facilities are available.

• Organize necessary public education and arrangements for cleaning and regular inspection/ supervision.

**Note:** If latrines are not fully used or maintained they will further discourage their use and possibly lead an increased health hazard.

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**Panel 2 – The Dangers of Insanitary Excreta Disposal**

**THE DANGERS OF INSANITARY EXCRETA DISPOSAL**

• Infectious diseases/pathogens in excreta pose a dangerous risk to others that may come in contact with it.

• Excreta can, unless properly isolated, provide a breeding ground for vectors, which then act as direct transmitters of disease.

Persons acting as carriers or transmitters of an infection sometimes show little or no sign of that disease. Conversely, persons in an advanced state of disease may have little or no importance in transmission.

• The safe disposal of human excreta is more important than disposal of animal waste, because human excreta transmit more diseases affecting humans. Human faeces are much more dangerous than urine – urine poses little risk. Children’s faeces are more dangerous than adult’s.

• Diseases that can be transmitted through faeces include: typhoid, cholera, bacillary and amoebic dysentery, infectious hepatitis, polio, bilharzia, roundworm, hookworm, miscellaneous diarrhoeas and gastroenteritis.

• The disposal of urine also requires special attention in those areas of Africa and the Middle East where the Schistosoma haematobium species of bilharzia occurs, and wherever typhoid is common and endemic. Elsewhere, it is probably sufficient, in an emergency, just to prevent contaminations of drinking/domestic water.

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**Chapter 19 – Annex 3: Environmental Sanitation**

**Objective**

To minimize the risks of disease by assuring an environment free from major health hazards due to solid or liquid wastes.

**Waste/Stagnant Water**

Drain waste and stagnant water away as quickly as possible to soakage pits or habitual watercourses: dig channels, pump or otherwise carry the water away. It not only smells unpleasant but also provides breeding places for insects, especially mosquitoes, and spreads infections.

If removal of stagnant water cannot be achieved quickly, it may be necessary to reduce risks by chlorinating it to kill pathogens, especially if there is a cholera outbreak and/or spraying to prevent mosquitoes breeding.
Wastewater generated from washing, bathing and food preparation should be localized at its sources and drained directly into local soakage pits or used to irrigate crops, as far as possible.

When restoring municipal piped water supplies, allow for additional water to flush out any piped sewerage networks that may exist. This flushing should be done before restoration of full supplies to all dwellings.

Solid Refuse/Garbage

The accumulation of refuse/garbage – and of animal manure – is both unpleasant and unhealthy. Rodent and insect–borne diseases increase with improper disposal. Appropriate arrangements must therefore be made and routines be (re–) established for its storage, collection and disposal. Note that free–range chickens, goats and pigs, when available, help control garbage. Dogs spread it.

The suggestions that follow particularly concern areas of high population density – urban areas or camps – where the problem and dangers are greatest.

Storage and Collection

For the initial cleaning up of accumulated garbage: Mobilize labour and some means of transporting the garbage to selected disposal sites/dumps.

To contain/collect each new day’s garbage: Place metal or plastic containers – e.g. 200 litre oil drums cut in half – in appropriate locations, providing lids, if possible, and punching drainage holes in the bottom.

For market areas and large institutions: Construct large rectangular bins with floors sloping down to a door at one end (from which the garbage can be shoveled out). Keep them covered, if possible, whenever garbage is not actually being deposited or removed. Spray the sites with insecticide daily.

Arrange for the garbage to be collected regularly, perhaps daily, from all containers. Give special attention to provisions for hospitals and health and feeding centres, and to similar community service institutions.

M. Assar’s, WHO Guide to Sanitation in Natural Disasters, suggests that one truck with a capacity of 10 cubic metres making 3 trips each day can clear the garbage produced by 5,000–8,000 people. UNHCR recommends a ratio of one container (rubbish bin) per 10 families in camp situations, with such containers being placed throughout the site in such a manner that no household is more than about 15 metres away from one. And that, each day the containers be collected and dumped into a waste–management site.

Disposal

Means of disposal will depend on the space and equipment available and on previous practices. Normally, garbage should be buried at designated locations or burned – using incinerators, if possible. In either case, the location should be well away from any dwellings and, preferably, fenced to restrict access. (It is, in an emergency phase, rarely feasible to segregate different types of garbage and organize the composting of degradable/organic material.)

If space and bulldozers are available, sanitary landfill disposal may be possible:

Ensure that the waste is dumped, under supervision, in large, especially dug/bulldozed trenches in flat areas, on small slopes, in hollows, or other suitable land:

- Ensure that site is properly assessed for any risk to water pollution.
- Sites should be at least 1 km or more downwind of major habitations and not close to watercourses.
- Deposited refuse should be compacted and, finally, covered with at least 50 cm of soil.
• The operation should, where appropriate, be integrated into any local land reclamation programme.

On a smaller scale, in rural areas, waste may be buried in hand-dug pits or trenches:

• A typical trench might be 1.5 m wide and 2 m deep.

• At the end of each day, refuse should be covered with a little earth to discourage insects and rodents.

• When full to within 40 cm of ground level, fill it in completely with earth, compact it and mark the site.

The contents can usually be dug out after 6 months and used on fields. M. Assar’s guide suggests that for each 1m length of trench, this may serve 200 people for about one week.

In many situations, it will be best/necessary to burn/incinerate all solid wastes.

Where there is, initially, no alternative to dumping garbage in open areas:

• Fence off an area;
• Crush tins to inhibit mosquitoes breeding in them when they fill with rainwater;
• Burn the waste as quickly as possible; and
• Cover the burned refuse with a little earth.

Medical waste should be treated separately, burning as much of it as possible without delay. Needles and scalpels are especially dangerous and should be properly incinerated and then buried.

Dust

Large amounts of dust carried in the air can cause eye irritations, and respiratory and skin problems, and contaminate food. Dust can also harm some types of equipment.

The best preventive measure is action to stop the destruction of vegetation in the vicinity. Spraying roads with water or oil, and controlling traffic can achieve dust control. This will rarely be possible on a large scale but might be considered around health facilities and feeding centres.

Possible UNICEF Inputs

Depending on the assessment of actual needs and possibilities, some of the following inputs might be considered:

• Expertise for assisting in planning and implementation of emergency arrangements.

• Materials for the re/establishment of garbage collection systems (bins, wheelbarrows and other equipment).

• Local costs, shovels, pitchforks, brushes, etc., for the removal of accumulated garbage.

Chapter 19 – Annex 4: Vector Control (Control of disease-carrying insects and rodents)
Objectives

To reduce the transmission of specific communicable diseases by directly or indirectly destroying, or at least containing, the carriers (‘vectors’) concerned. And reduce losses and contamination of food stocks by rodents.

Priorities

• Specific control measures
• Possible UNICEF inputs

Likely Problems

Emergencies often create environments typically favourable to the proliferation of disease-carrying insects and rodents, which can also spoil or destroy large quantities of food. Flies, mosquitoes and rodents can be very difficult to reduce quickly in the aftermath of an emergency. Therefore, both immediate and medium-term strategies must be employed.

Panel 1 lists common vectors, related diseases and the environments/conditions under which the vectors are likely to proliferate. Note also that:

• Crowding – of displaced persons and others – greatly increases the risks of exposure to vectors and of disease transmission.

• Previous long-term control operations, if any, may also have been interrupted by the emergency.

Organizing a Response

Essential initial actions are:

• Assessment by an experienced professional (preferably local) of the influence of events on the status and breeding potential of various prevalent vectors.

• A population survey for lice, fleas and ticks if many people appear to be suffering from such infestations.

• A survey to determine the extent and location of rodent (rat) infestations – their major harbourages and runs.

• A review of the problems with members and leaders of the community including explanation/education on the significance and possible means of vector control and improved personal hygiene.

Actions

• Give top priority to improving general environmental sanitation (disposal of excreta, garbage and waste water), personal hygiene (requiring adequate soap and water) and the careful storage of food and water.

• Intensify/initiate appropriate chemical control measures against mosquitoes and rodents, where necessary.

Physical screens/mosquito nets may be used against mosquitoes, especially in health and feeding centres and for pregnant women and under five children.
Professional expertise with local knowledge and experience is necessary to plan and supervise control measures, especially the choice and use of chemicals, taking account of any insecticide resistance in local vectors and pests.

Control measures should be undertaken as part of, or at least in close coordination with, the relevant national programmes and practices. The measures used in previous long-term programmes should normally be maintained, but emergency operations may need to be refocused and rescheduled/accelerated in relation to the new circumstances.

Priority should be given to areas of high population density and to those subject to particular seasonal factors (such as inaccessibility during rains). Follow-up surveys are essential to evaluate the effectiveness of measures taken.

**Specific Control Measures**

**Mosquitoes**

Essential actions:

- Improve drainage and eliminate stagnant pools where mosquitoes are likely to breed.
- Spray important resting-places of adult mosquitoes with specific insecticides.
- Spray standing water with larvicides or growth inhibitors.
- Space spray by air or ground (e.g. vehicle-mounted) equipment, particularly for yellow fever and dengue vectors.
- Eliminate, to the extent practicable, habitats – especially stagnant water, empty tins, etc.
- Promote the use of bed nets to protect pregnant women and under-five children against malaria.

**Flies**

The presence of many flies clearly indicates a dirty environment. Essential actions include:

- Good general sanitation, especially the disposal of all organic waste, including dead animals.
- Making latrines as fly-proof as possible.
- Physical screening of windows in hospitals and in health and feeding centre kitchens.
- Spraying garbage containers occasionally with insecticide. (It is often advisable to rotate between different chemicals in spraying operations.)

**Rodents (rats)**

Essential actions:

- Dust specifically identified rat ‘runs’ with an appropriate rodenticide.
- Place baited traps in warehouses.
Attention should be given first to any crowded temporary camp settlements, food warehouses in ports and elsewhere, markets and hospitals. Rodenticides, if used, should normally be ‘chronic’ (slow acting) rather than ‘acute’.

In areas where plague or other arthropod–borne diseases are endemic, action must be taken to control the flies, tics or other vectors carried by rats before any large–scale control of rodents is attempted – especially through the use of large numbers of snap traps. Otherwise, fleas transferring from the dead rats to humans may precipitate an epidemic of plague!

Care must be taken in disposing of dead rats that may be carrying plague–bearing fleas. Wear gloves. Incinerate the bodies if possible, otherwise bury them in a deep hole well away from any water including groundwater.

Lice

Essential actions:

- Improved personal hygiene!
- Mass de–lousing of people, clothes and bedding by dusting with insecticide (e.g. 1 percent lindane) if problems are severe.

Lice are found mainly on collars, waistbands and seams. Washing clothes is only effective if the water temperature is maintained at least 54 ° C, which is rarely possible. Dusting with insecticide is best done using compressed air equipment.

Fleas

Essential actions:

- Dusting of rodent runs and fumigation of their burrows with appropriate insecticides.
- Insecticide treatment of bedding may be necessary; but infants’ bedding should not be treated, only washed.
- Where flea–borne diseases are prevalent, applications to persons’ bodies and clothes may be required.

Where no flea–borne diseases are prevalent, fleas may be removed by hand from bodies of persons infested, and by combing them from the bodies of infested domestic animals; fleas should be immediately crushed to kill them.

Ticks

Tick problems may be effectively reduced by applying acaricide in outdoor areas where ticks are prevalent or by clearing vegetation for 50–100 metres around camps/villages. Indoor applications of acaricides may be necessary where large numbers of ticks are found inside dwellings – but caution must be taken to keep children and others safely away during this operation.

Bedbugs

Simple methods such as beating bedding and furniture outdoors, well away from dwellings, or pouring hot water over bed frames, can reduce infestations. With heavy infestations, it may be necessary to apply insecticide to beds, mattresses, crevices in walls and furniture – but infant bedding, including cribs, should not be treated with insecticide. Treated bedding must be dried completely before reuse.
Possible UNICEF Inputs

Depending on the assessment of actual needs and possibilities, some of the following inputs might be considered:

- Appropriate chemicals and sprayers.
- Personal equipment for survey teams (collection jars, protection clothing, lamps, etc.).
- Transport, local operating costs.
- Mosquito nets for pregnant women and under-five children.
- Soap for domestic and institutional use, detergent and disinfectant for institutional use.
- Appropriate essential drugs for treatment, especially Benzyl Benzoate against scabies and lice.
- Materials and local costs for health education campaigns.

Further References

Emergency vector control after natural disaster, Scientific publication No. 419 – PAHO (1982)


Panels

Panel 1 – Vectors which May Pose Significant Health Risks

<table>
<thead>
<tr>
<th>Vector</th>
<th>Risks</th>
<th>Favourable environments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flies</td>
<td>Eye infections (particularly among infants and children); diarrhoeal diseases</td>
<td>Exposed food; excreta; dead animals.</td>
</tr>
<tr>
<td>Mosquitoes</td>
<td>Malaria; filariasis, encephalitis;</td>
<td>Stagnant water, especially in the periphery of inundated areas; pools and slow-moving water.</td>
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<tr>
<td></td>
<td>Yellow fever, dengue</td>
<td>Stored water in or around dwellings; accumulations or rain water in old tins and other containers.</td>
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<tr>
<td>Mites</td>
<td>Scabies, scrubs, typhus</td>
<td>Overcrowding and poor personal hygiene</td>
</tr>
<tr>
<td>Lice</td>
<td>Plague (from infected rats), endemic typhus</td>
<td></td>
</tr>
<tr>
<td>Fleas</td>
<td>Relapsing fever, spotted fever</td>
<td></td>
</tr>
<tr>
<td>Ticks</td>
<td>Rat bite fever, leptospirosis, salmonellosis</td>
<td>Inadequately protected food; exposed garbage; covered spaces</td>
</tr>
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</table>
Insects can also cause bites and/or annoyances!

Charter of the United Nations

Preamble

WE THE PEOPLES OF THE UNITED NATIONS DETERMINED

to save succeeding generations from the scourge of war, which twice in our lifetime has brought untold sorrow to mankind, and

to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small, and

to establish conditions under which justice and respect for the obligations arising from treaties and other sources of international law can be maintained, and

to promote social progress and better standards of life in larger freedom,

AND FOR THESE ENDS

to practice tolerance and live together in peace with one another as good neighbors, and

to unite our strength to maintain international peace and security, and

to ensure by the acceptance of principles and the institution of methods, that armed force shall not be used, save in the common interest, and

to employ international machinery for the promotion of the economic and social advancement of all peoples,

HAVE RESOLVED TO COMBINE OUR EFFORTS TO ACCOMPLISH THESE AIMS

Accordingly, our respective Governments, through representatives assembled in the city of San Francisco, who have exhibited their full powers found to be in good and due form, have agreed to the present Charter of the United Nations and do hereby establish an international organization to be known as the United Nations.

CHAPTER I

PURPOSES AND PRINCIPLES

Article 1

The Purposes of the United Nations are:

1. To maintain international peace and security, and to that end: to take effective collective measures for the prevention and removal of threats to the peace, and for the suppression of acts of aggression or other breaches of the peace, and to bring about by peaceful means, and in conformity with the principles of justice and international law, adjustment or settlement of international disputes or situations which might lead to a breach of the peace;

2. To develop friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, and to take other appropriate measures to strengthen universal peace;

3. To achieve international cooperation in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex,
language, or religion; and

4. To be a center for harmonizing the actions of nations in the attainment of these common ends.

Article 2

The Organization and its Members, in pursuit of the Purposes stated in Article 1, shall act in accordance with the following Principles.

1. The Organization is based on the principle of the sovereign equality of all its Members.

2. All Members, in order to ensure to all of them the rights and benefits resulting from membership, shall fulfill in good faith the obligations assumed by them in accordance with the present Charter.

3. All Members shall settle their international disputes by peaceful means in such a manner that international peace and security, and justice, are not endangered.

4. All Members shall refrain in their international relations from the threat or use of force against the territorial integrity or political independence of any state, or in any other manner inconsistent with the Purposes of the United Nations.

5. All Members shall give the United Nations every assistance in any action it takes in accordance with the present Charter, and shall refrain from giving assistance to any state against which the United Nations is taking preventive or enforcement action.

6. The Organization shall ensure that states which are not Members of the United Nations act in accordance with these Principles so far as may be necessary for the maintenance of international peace and security.

7. Nothing contained in the present Charter shall authorize the United Nations to intervene in matters which are essentially within the domestic jurisdiction of any state or shall require the Members to submit such matters to settlement under the present Charter; but this principle shall not prejudice the application of enforcement measures under Chapter VII.

CHAPTER II

MEMBERSHIP

Article 3

The original Members of the United Nations shall be the states which, having participated in the United Nations Conference on International Organization at San Francisco, or having previously signed the Declaration by United Nations of January 1, 1942, sign the present Charter and ratify it in accordance with Article 110.

Article 4

1. Membership in the United Nations is open to all other peace−loving states which accept the obligations contained in the present Charter and, in the judgment of the Organization, are able and willing to carry out these obligations.

2. The admission of any such state to membership in the United Nations will be effected by a decision of the General Assembly upon the recommendation of the Security Council.

Article 5

A member of the United Nations against which preventive or enforcement action has been taken by the Security Council may be suspended from the exercise of the rights and privileges of membership by the General Assembly upon the recommendation of the Security Council. The exercise of these rights and privileges may be restored by the Security Council.
Article 6

A Member of the United Nations which has persistently violated the Principles contained in the present Charter may be expelled from the Organization by the General Assembly upon the recommendation of the Security Council.

CHAPTER III

ORGANS

Article 7

1. There are established as the principal organs of the United Nations: a General Assembly, a Security Council, an Economic and Social Council, a Trusteeship Council, an International Court of Justice, and a Secretariat.

2. Such subsidiary organs as may be found necessary may be established in accordance with the present Charter.

Article 8

The United Nations shall place no restrictions on the eligibility of men and women to participate in any capacity and under conditions of equality in its principal and subsidiary organs.

CHAPTER IV

THE GENERAL ASSEMBLY

Article 9

Composition

1. The General Assembly shall consist of all the Members of the United Nations.

2. Each member shall have not more than five representatives in the General Assembly.

Functions and Powers

Article 10

The General Assembly may discuss any questions or any matters within the scope of the present Charter or relating to the powers and functions of any organs provided for in the present Charter, and, except as provided in Article 12, may make recommendations to the Members of the United Nations or to the Security Council or to both on any such questions or matters.

Article 11

1. The General Assembly may consider the general principles of cooperation in the maintenance of international peace and security, including the principles governing disarmament and the regulation of armaments, and may make recommendations with regard to such principles to the Members or to the Security Council or to both.

2. The General Assembly may discuss any questions relating to the maintenance of international peace and security brought before it by any Member of the United Nations, or by the Security Council, or by a state which is not a Member of the United Nations in accordance with Article 35, paragraph 2, and, except as provided in Article 12, may make recommendations with regard to any such questions to the state or states concerned or to the Security Council or to both. Any such question on which action is necessary shall be referred to the Security Council by the General Assembly either before or after discussion.
3. The General Assembly may call the attention of the Security Council to situations which are likely to endanger international peace and security.

4. The powers of the General Assembly set forth in this Article shall not limit the general scope of Article 10.

**Article 12**

1. While the Security Council is exercising in respect of any dispute or situation the functions assigned to it in the present Charter, the General Assembly shall not make any recommendation with regard to that dispute or situation unless the Security Council so requests.

2. The Secretary−General, with the consent of the Security Council, shall notify the General Assembly at each session of any matters relative to the maintenance of international peace and security which are being dealt with by the Security Council and shall similarly notify the General Assembly, or the Members of the United Nations if the General Assembly is not in session, immediately the Security Council ceases to deal with such matters.

**Article 13**

1. The General Assembly shall initiate studies and make recommendations for the purpose of:

   a. promoting international cooperation in the political field and encouraging the progressive development of international law and its codification;

   b. promoting international cooperation in the economic, social, cultural, educational, and health fields, and assisting in the realization of human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

2. The further responsibilities, functions and powers of the General Assembly with respect to matters mentioned in paragraph 1(b) above are set forth in Chapters IX and X.

**Article 14**

Subject to the provisions of Article 12, the General Assembly may recommend measures for the peaceful adjustment of any situation, regardless of origin, which it deems likely to impair the general welfare or friendly relations among nations, including situations resulting from a violation of the provisions of the present Charter setting forth the Purposes and Principles of the United Nations.

**Article 15**

1. The General Assembly shall receive and consider annual and special reports from the Security Council; these reports shall include an account of the measures that the Security Council has decided upon or taken to maintain international peace and security.

2. The General Assembly shall receive and consider reports from the other organs of the United Nations.

**Article 16**

The General Assembly shall perform such functions with respect to the international trusteeship system as are assigned to it under Chapters XII and XIII, including the approval of the trusteeship agreements for areas not designated as strategic.

**Article 17**

1. The General Assembly shall consider and approve the budget of the Organization.
2. The expenses of the Organization shall be borne by the Members as apportioned by the General Assembly.

3. The General Assembly shall consider and approve any financial and budgetary arrangements with specialized agencies referred to in Article 57 and shall examine the administrative budgets of such specialized agencies with a view to making recommendations to the agencies concerned.

Voting

**Article 18**

1. Each member of the General Assembly shall have one vote.

2. Decisions of the General Assembly on important questions shall be made by a two-thirds majority of the members present and voting. These questions shall include: recommendations with respect to the maintenance of international peace and security, the election of the non-permanent members of the Security Council, the election of the members of the Economic and Social Council, the election of members of the Trusteeship Council in accordance with paragraph 1(c) of Article 86, the admission of new Members to the United Nations, the suspension of the rights and privileges of membership, the expulsion of Members, questions relating to the operation of the trusteeship system, and budgetary questions.

3. Decisions on other questions, Composition including the determination of additional categories of questions to be decided by a two-thirds majority, shall be made by a majority of the members present and voting.

**Article 19**

A Member of the United Nations which is in arrears in the payment of its financial contributions to the Organization shall have no vote in the General Assembly if the amount of its arrears equals or exceeds the amount of the contributions due from it for the preceding two full years. The General Assembly may, nevertheless, permit such a Member to vote if it is satisfied that the failure to pay is due to conditions beyond the control of the Member.

Procedure

**Article 20**

The General Assembly shall meet in regular annual sessions and in such special sessions as occasion may require. Special sessions shall be convoked by the Secretary-General at the request of the Security Council or of a majority of the Members of the United Nations.

**Article 21**

The General Assembly shall adopt its own rules of procedure. It shall elect its President for each session.

**Article 22**

The General Assembly may establish such subsidiary organs as it deems necessary for the performance of its functions.

**CHAPTER V**

**THE SECURITY COUNCIL**

**Article 23**

1. The Security Council shall consist of fifteen Members of the United Nations. The Republic of China, France, the Union of Soviet Socialist Republics, the United Kingdom of Great Britain
and Northern Ireland, and the United States of America shall be permanent members of the Security Council. The General Assembly shall elect ten other Members of the United Nations to be non-permanent members of the Security Council, due regard being specially paid, in the first instance to the contribution of Members of the United Nations to the maintenance of international peace and security and to the other purposes of the Organization, and also to equitable geographical distribution.

The non-permanent members of the Security Council shall be elected for a term of two years. In the first election of the non-permanent members after the increase of the membership of the Security Council from eleven to fifteen, two of the four additional members shall be chosen for a term of one year. A retiring member shall not be eligible for immediate re-election.

Each member of the Security Council shall have one representative.

Functions and Powers

**Article 24**

1. In order to ensure prompt and effective action by the United Nations, its Members confer on the Security Council primary responsibility for the maintenance of international peace and security, and agree that in carrying out its duties under this responsibility the Security Council acts on their behalf.

2. In discharging these duties the Security Council shall act in accordance with the Purposes and Principles of the United Nations. The specific powers granted to the Security Council for the discharge of these duties are laid down in Chapters VI, VII, VIII, and XII.

3. The Security Council shall submit annual and, when necessary, special reports to the General Assembly for its consideration.

**Article 25**

The Members of the United Nations agree to accept and carry out the decisions of the Security Council in accordance with the present Charter.

**Article 26**

In order to promote the establishment and maintenance of international peace and security with the least diversion for armaments of the world’s human and economic resources, the Security Council shall be responsible for formulating, with the assistance of the Military Staff Committee referred to in Article 47, plans to be submitted to the Members of the United Nations for the establishment of a system for the regulation of armaments.

Voting

**Article 27**

1. Each member of the Security Council shall have one vote.

2. Decisions of the Security Council on procedural matters shall be made by an affirmative vote of nine members.

3. Decisions of the Security Council on all other matters shall be made by an affirmative vote of nine members including the concurring votes of the permanent members; provided that, in decisions under Chapter VI, and under paragraph 3 of Article 52, a party to a dispute shall abstain from voting.

Procedure

**Article 28**

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1. The Security Council shall be so organized as to be able to function continuously. Each member of the Security Council shall for this purpose be represented at all times at the seat of the Organization.

2. The Security Council shall hold periodic meetings at which each of its members may, if it so desires, be represented by a member of the government or by some other specially designated representative.

3. The Security Council may hold meetings at such places other than the seat of the Organization as in its judgment will best facilitate its work.

**Article 29**

The Security Council may establish such subsidiary organs as it deems necessary for the performance of its functions.

**Article 30**

The Security Council shall adopt its own rules of procedure, including the method of selecting its President.

**Article 31**

Any Member of the United Nations which is not a member of the Security Council may participate, without vote, in the discussion of any question brought before the Security Council whenever the latter considers that the interests of that Member are specially affected.

**Article 32**

Any Member of the United Nations which is not a member of the Security Council or any state which is not a Member of the United Nations, if it is a party to a dispute under consideration by the Security Council, shall be invited to participate, without vote, in the discussion relating to the dispute. The Security Council shall lay down such conditions as it deems just for the participation of a state which is not a Member of the United Nations.

CHAPTER VI

PACIFIC SETTLEMENT OF DISPUTES

**Article 33**

1. The parties to any dispute, the continuance of which is likely to endanger the maintenance of international peace and security, shall, first of all, seek a solution by negotiation, enquiry, mediation, conciliation, arbitration, judicial settlement, resort to regional agencies or arrangements, or other peaceful means of their own choice.

2. The Security Council shall, when it deems necessary, call upon the parties to settle their dispute by such means.

**Article 34**

The Security Council may investigate any dispute, or any situation which might lead to international friction or give rise to a dispute, in order to determine whether the continuance of the dispute or situation is likely to endanger the maintenance of international peace and security.

**Article 35**

1. Any Member of the United Nations may bring any dispute, or any situation of the nature referred to in Article 34, to the attention of the Security Council or of the General Assembly.
2. A state which is not a Member of the United Nations may bring to the attention of the Security Council or of the General Assembly any dispute to which it is a party if it accepts in advance, for the purposes of the dispute, the obligations of pacific settlement provided in the present Charter.

3. The proceedings of the General Assembly in respect of matters brought to its attention under this Article will be subject to the provisions of Articles 11 and 12.

**Article 36**

1. The Security Council may, at any stage of a dispute of the nature referred to in Article 33 or of a situation of like nature, recommend appropriate procedures or methods of adjustment.

2. The Security Council should take into consideration any procedures for the settlement of the dispute which have already been adopted by the parties.

3. In making recommendations under this Article the Security Council should also take into consideration that legal disputes should as a general rule be referred by the parties to the International Court of Justice in accordance with the provisions of the Statute of the Court.

**Article 37**

1. Should the parties to a dispute of the nature referred to in Article 33 fail to settle it by the means indicated in that Article, they shall refer it to the Security Council.

2. If the Security Council deems that the continuance of the dispute is in fact likely to endanger the maintenance of international peace and security, it shall decide whether to take action under Article 36 or to recommend such terms of settlement as it may consider appropriate.

**Article 38**

Without prejudice to the provisions of Articles 33 to 37, the Security Council may, if all the parties to any dispute so request, make recommendations to the parties with a view to a pacific settlement of the dispute.

**CHAPTER VII**

**ACTION WITH RESPECT TO THREATS TO THE PEACE, BREACHES OF THE PEACE, AND ACTS OF AGGRESSION**

**Article 39**

The Security Council shall determine the existence of any threat to the peace, breach of the peace, or act of aggression and shall make recommendations, or decide what measures shall be taken in accordance with Articles 41 and 42, to maintain or restore international peace and security.

**Article 40**

In order to prevent an aggravation of the situation, the Security Council may, before making the recommendations or deciding upon the measures provided for in Article 39, call upon the parties concerned to comply with such provisional measures as it deems necessary or desirable. Such provisional measures shall be without prejudice to the rights, claims, or position of the parties concerned. The Security Council shall duly take account of failure to comply with such provisional measures.

**Article 41**

The Security Council may decide what measures not involving the use of armed force are to be employed to give effect to its decisions, and it may call upon the Members of the United Nations to apply such measures. These may include complete or partial interruption of
economic relations and of rail, sea, air, postal, telegraphic, radio, and other means of communication, and the severance of diplomatic relations.

Article 42

Should the Security Council consider that measures provided for in Article 41 would be inadequate or have proved to be inadequate, it may take such action by air, sea, or land forces as may be necessary to maintain or restore international peace and security. Such action may include demonstrations, blockade, and other operations by air, sea, or land forces of Members of the United Nations.

Article 43

1. All Members of the United Nations, in order to contribute to the maintenance of international peace and security, undertake to make available to the Security Council, on its call and in accordance with a special agreement or agreements, armed forces, assistance, and facilities, including rights of passage, necessary for the purpose of maintaining international peace and security.

2. Such agreement or agreements shall govern the numbers and types of forces, their degree of readiness and general location, and the nature of the facilities and assistance to be provided.

3. The agreement or agreements shall be negotiated as soon as possible on the initiative of the Security Council. They shall be concluded between the Security Council and Members or between the Security Council and groups of Members and shall be subject to ratification by the signatory states in accordance with their respective constitutional processes.

Article 44

When the Security Council has decided to use force it shall, before calling upon a Member not represented on it to provide armed forces in fulfillment of the obligations assumed under Article 43, invite that Member, if the Member so desires, to participate in the decisions of the Security Council concerning the employment of contingents of that Member's armed forces.

Article 45

In order to enable the United Nations to take urgent military measures Members shall hold immediately available national air−force contingents for combined international enforcement action. The strength and degree of readiness of these contingents and plans for their combined action shall be determined, within the limits laid down in the special agreement or agreements referred to in Article 43, by the Security Council with the assistance of the Military Staff Committee.

Article 46

Plans for the application of armed force shall be made by the Security Council with the assistance of the Military Staff Committee.

Article 47

1. There shall be established a Military Staff Committee to advise and assist the Security Council on all questions relating to the Security Council's military requirements for the maintenance of international peace and security, the employment and command of forces placed at its disposal, the regulation of armaments, and possible disarmament.

2. The Military Staff Committee shall consist of the Chiefs of Staff of the permanent members of the Security Council or their representatives. Any Member of the United Nations not permanently represented on the Committee shall be invited by the Committee to be associated with it when the efficient discharge of the Committee's responsibilities requires the participation of that Member in its work.
3. The Military Staff Committee shall be responsible under the Security Council for the strategic direction of any armed forces placed at the disposal of the Security Council. Questions relating to the command of such forces shall be worked out subsequently.

4. The Military Staff Committee, with the authorization of the Security Council and after consultation with appropriate regional agencies, may establish regional subcommittees.

**Article 48**

1. The action required to carry out the decisions of the Security Council for the maintenance of international peace and security shall be taken by all the Members of the United Nations or by some of them, as the Security Council may determine.

2. Such decisions shall be carried out by the Members of the United Nations directly and through their action in the appropriate international agencies of which they are members.

**Article 49**

The Members of the United Nations shall join in affording mutual assistance in carrying out the measures decided upon by the Security Council.

**Article 50**

If preventive or enforcement measures against any state are taken by the Security Council, any other state, whether a Member of the United Nations or not, which finds itself confronted with special economic problems arising from the carrying out of those measures shall have the right to consult the Security Council with regard to a solution of those problems.

**Article 51**

Nothing in the present Charter shall impair the inherent right of individual or collective self−defense if an armed attack occurs against a Member of the United Nations, until the Security Council has taken measures necessary to maintain international peace and security. Measures taken by Members in the exercise of this right of self−defense shall be immediately reported to the Security Council and shall not in any way affect the authority and responsibility of the Security Council under the present Charter to take at any time such action as it deems necessary in order to maintain or restore international peace and security.

**CHAPTER VIII**

**REGIONAL ARRANGEMENTS**

**Article 52**

1. Nothing in the present Charter precludes the existence of regional arrangements or agencies for dealing with such matters relating to the maintenance of international peace and security as are appropriate for regional action, provided that such arrangements or agencies and their activities are consistent with the Purposes and Principles of the United Nations.

2. The Members of the United Nations entering into such arrangements or constituting such agencies shall make every effort to achieve pacific settlement of local disputes through such regional arrangements or by such regional agencies before referring them to the Security Council.

3. The Security Council shall encourage the development of pacific settlement of local disputes through such regional arrangements or by such regional agencies either on the initiative of the states concerned or by reference from the Security Council.

4. This Article in no way impairs the application of Articles 34 and 35.

**Article 53**
1. The Security Council shall, where appropriate, utilize such regional arrangements or agencies for enforcement action under its authority. But no enforcement action shall be taken under regional arrangements or by regional agencies without the authorization of the Security Council, with the exception of measures against any enemy state, as defined in paragraph 2 of this Article, provided for pursuant to Article 107 or in regional arrangements directed against renewal of aggressive policy on the part of any such state, until such time as the Organization may, on request of the Governments concerned, be charged with the responsibility for preventing further aggression by such a state.

2. The term enemy state as used in paragraph 1 of this Article applies to any state which during the Second World War has been an enemy of any signatory of the present Charter.

**Article 54**

The Security Council shall at all times be kept fully informed of activities undertaken or in contemplation under regional arrangements or by regional agencies for the maintenance of international peace and security.

**CHAPTER IX**

INTERNATIONAL ECONOMIC AND SOCIAL CO−OPERATION

**Article 55**

With a view to the creation of conditions of stability and well−being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self−determination of peoples, the United Nations shall promote:

a. higher standards of living, full employment, and conditions of economic and social progress and development;

b. solutions of international economic, social, health, and related problems; and international cultural and educational co−operation; and

c. universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

**Article 56**

All Members pledge themselves to take joint and separate action in cooperation with the Organization for the achievement of the purposes set forth in Article 55.

**Article 57**

1. The various specialized agencies, established by intergovernmental agreement and having wide international responsibilities, as defined in their basic instruments, in economic, social, cultural, educational, health, and related fields, shall be brought into relationship with the United Nations in accordance with the provisions of Article 63.

2. Such agencies thus brought into relationship with the United Nations are hereinafter referred to as specialized agencies.

**Article 58**

The Organization shall make recommendations for the coordination of the policies and activities of the specialized agencies.

**Article 59**

The Organization shall, where appropriate, initiate negotiations among the states concerned for the creation of any new specialized agencies required for the accomplishment of the purposes set forth in Article 55.
Article 60

Responsibility for the discharge of the functions of the Organization set forth in this Chapter shall be vested in the General Assembly and, under the authority of the General Assembly, in the Economic and Social Council, which shall have for this purpose the powers set forth in Chapter X.

CHAPTER X

THE ECONOMIC AND SOCIAL COUNCIL

Composition

Article 61

1. The Economic and Social Council shall consist of fifty-four Members of the United Nations elected by the General Assembly.

2. Subject to the provisions of paragraph 3, eighteen members of the Economic and Social Council shall be elected each year for a term of three years. A retiring member shall be eligible for immediate re-election.

3. At the first election after the increase in the membership of the Economic and Social Council from twenty-seven to fifty-four members, in addition to the members elected in place of the nine members whose term of office expires at the end of that year, twenty-seven additional members shall be elected. Of these twenty-seven additional members, the term of office of nine members so elected shall expire at the end of one year, and of nine other members at the end of two years, in accordance with arrangements made by the General Assembly.

4. Each member of the Economic and Social Council shall have one representative.

Functions and Powers

Article 62

1. The Economic and Social Council may make or initiate studies and reports with respect to international economic, social, cultural, educational, health, and related matters and may make recommendations with respect to any such matters to the General Assembly, to the Members of the United Nations, and to the specialized agencies concerned.

2. It may make recommendations for the purpose of promoting respect for, and observance of, human rights and fundamental freedoms for all.

3. It may prepare draft conventions for submission to the General Assembly, with respect to matters falling within its competence.

4. It may call, in accordance with the rules prescribed by the United Nations, international conferences on matters falling within its competence.

Article 63

1. The Economic and Social Council may enter into agreements with any of the agencies referred to in Article 57, defining the terms on which the agency concerned shall be brought into relationship with the United Nations. Such agreements shall be subject to approval by the General Assembly.

2. It may coordinate the activities of the specialized agencies through consultation with and recommendations to such agencies and through recommendations to the General Assembly and to the Members of the United Nations.

Article 64

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1. The Economic and Social Council may take appropriate steps to obtain regular reports from the specialized agencies. It may make arrangements with the Members of the United Nations and with the specialized agencies to obtain reports on the steps taken to give effect to its own recommendations and to recommendations on matters falling within its competence made by the General Assembly.

2. It may communicate its observations on these reports to the General Assembly.

Article 65

The Economic and Social Council may furnish information to the Security Council and shall assist the Security Council upon its request.

Article 66

1. The Economic and Social Council shall perform such functions as fall within its competence in connection with the carrying out of the recommendations of the General Assembly.

2. It may, with the approval of the General Assembly, perform services at the request of Members of the United Nations and at the request of specialized agencies.

3. It shall perform such other functions as are specified elsewhere in the present Charter or as may be assigned to it by the General Assembly.

Article 67

1. Each member of the Economic and Social Council shall have one vote.

2. Decisions of the Economic and Social Council shall be made by a majority of the members present and voting.

Procedure

Article 68

The Economic and Social Council shall set up commissions in economic and social fields and for the promotion of human rights, and such other commissions as may be required for the performance of its functions.

Article 69

The Economic and Social Council shall invite any Member of the United Nations to participate, without vote, in its deliberations on any matter of particular concern to that Member.

Article 70

The Economic and Social Council may make arrangements for representatives of the specialized agencies to participate, without vote, in its deliberations and in those of the commissions established by it, and for its representatives to participate in the deliberations of the specialized agencies.

Article 71

The Economic and Social Council may make suitable arrangements for consultation with non-governmental organizations which are concerned with matters within its competence. Such arrangements may be made with international organizations and, where appropriate, with national organizations after consultation with the Member of the United Nations concerned.

Article 72
1. The Economic and Social Council shall adopt its own rules of procedure, including the method of selecting its President.

2. The Economic and Social Council shall meet as required in accordance with its rules, which shall include provision for the convening of meetings on the request of a majority of its members.

CHAPTER XI
DECLARATION REGARDING NON−SELF−GOVERNING TERRITORIES

Article 73

Members of the United Nations which have or assume responsibilities for the administration of territories whose peoples have not yet attained a full measure of self–government recognize the principle that the interests of the inhabitants of these territories are paramount, and accept as a sacred trust the obligation to promote to the utmost, within the system of international peace and security established by the present Charter, the well−being of the inhabitants of these territories, and, to this end:

a. to ensure, with due respect for the culture of the peoples concerned, their political, economic, social, and educational advancement, their just treatment, and their protection against abuses;

b. to develop self−government, to take due account of the political aspirations of the peoples, and to assist them in the progressive development of their free political institutions, according to the particular circumstances of each territory and its peoples and their varying stages of advancement;

c. to further international peace and security;

d. to promote constructive measures of development, to encourage research, and to cooperate with one another and, when and where appropriate, with specialized international bodies with a view to the practical achievement of the social, economic, and scientific purposes set forth in this Article; and

e. to transmit regularly to the Secretary−General for information purposes, subject to such limitation as security and constitutional considerations may require, statistical and other information of a technical nature relating to economic, social, and educational conditions in the territories for which they are respectively responsible other than those territories to which Chapter XII and XIII apply.

Article 74

Members of the United Nations also agree that their policy in respect of the territories to which this Chapter applies, no less than in respect of their metropolitan areas, must be based on the general principle of good−neighborliness, due account being taken of the interests and well−being of the rest of the world, in social, economic, and commercial matters.

CHAPTER XII
INTERNATIONAL TRUSTEESHIP SYSTEM

Article 75

The United Nations shall establish under its authority an international trusteeship system for the administration and supervision of such territories as may be placed thereunder by subsequent individual agreements. These territories are hereinafter referred to as trust territories.

Article 76
The basic objectives of the trusteeship system, in accordance with the Purposes of the United Nations laid down in Article 1 of the present Charter, shall be:

a. to further international peace and security;

b. to promote the political, economic, social, and educational advancement of the inhabitants of the trust territories, and their progressive development towards self-government or independence as may be appropriate to the particular circumstances of each territory and its peoples and the freely expressed wishes of the peoples concerned, and as may be provided by the terms of each trusteeship agreement;

c. to encourage respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion, and to encourage recognition of the interdependence of the peoples of the world; and

d. to ensure equal treatment in social, economic, and commercial matters for all Members of the United Nations and their nationals and also equal treatment for the latter in the administration of justice without prejudice to the attainment of the foregoing objectives and subject to the provisions of Article 80.

**Article 77**

1. The trusteeship system shall apply to such territories in the following categories as may be placed thereunder by means of trusteeship agreements:

   a. territories now held under mandate;

   b. territories which may be detached from enemy states as a result of the Second World War, and

   c. territories voluntarily placed under the system by states responsible for their administration.

2. It will be a matter for subsequent agreement as to which territories in the foregoing categories will be brought under the trusteeship system and upon what terms.

**Article 78**

The trusteeship system shall not apply to territories which have become Members of the United Nations, relationship among which shall be based on respect for the principle of sovereign equality.

**Article 79**

The terms of trusteeship for each territory to be placed under the trusteeship system, including any alteration or amendment, shall be agreed upon by the states directly concerned, including the mandatory power in the case of territories held under mandate by a Member of the United Nations, and shall be approved as provided for in Articles 83 and 85.

**Article 80**

1. Except as may be agreed upon in individual trusteeship agreements, made under Articles 77, 79, and 81, placing each territory under the trusteeship system, and until such agreements have been concluded, nothing in this Chapter shall be construed in or of itself to alter in any manner the rights whatsoever of any states or any peoples or the terms of existing international instruments to which Members of the United Nations may respectively be parties.

2. Paragraph 1 of this Article shall not be interpreted as giving grounds for delay or postponement of the negotiation and conclusion of agreements for placing mandated and other territories under the trusteeship system as provided for in Article 77.

**Article 81**
The trusteeship agreement shall in each case include the terms under which the trust territory will be administered and designate the authority which will exercise the administration of the trust territory. Such authority, hereinafter called the administering authority, may be one or more states or the Organization itself.

Article 82

There may be designated, in any trusteeship agreement, a strategic area or areas which may include part or all of the trust territory to which the agreement applies, without prejudice to any special agreement or agreements made under Article 43.

Article 83

1. All functions of the United Nations relating to strategic areas, including the approval of the terms of the trusteeship agreements and of their alteration or amendment, shall be exercised by the Security Council.

2. The basic objectives set forth in Article 76 shall be applicable to the people of each strategic area.

3. The Security Council shall, subject to the provisions of the trusteeship agreements and without prejudice to security considerations, avail itself of the assistance of the Trusteeship Council to perform those functions of the United Nations under the trusteeship system relating to political, economic, social, and educational matters in the strategic areas.

Article 84

It shall be the duty of the administering authority to ensure that the trust territory shall play its part in the maintenance of international peace and security. To this end the administering authority may make use of volunteer forces, facilities, and assistance from the trust territory in carrying out the obligations towards the Security Council undertaken in this regard by the administering authority, as well as for local defense and the maintenance of law and order within the trust territory.

Article 85

1. The functions of the United Nations with regard to trusteeship agreements for all areas not designated as strategic, including the approval of the terms of the trusteeship agreements and of their alteration or amendment, shall be exercised by the General Assembly.

2. The Trusteeship Council, operating under the authority of the General Assembly, shall assist the General Assembly in carrying out these functions.

CHAPTER XIII

THE TRUSTEESHIP COUNCIL

Composition

Article 86

1. The Trusteeship Council shall consist of the following Members of the United Nations:
   a. those Members administering trust territories;
   b. such of those Members mentioned by name in Article 23 as are not administering trust territories; and
   c. as many other Members elected for three−year terms by the General Assembly as may be necessary to ensure that the total number of members of the Trusteeship Council is equally divided between those Members of the United Nations which administer trust territories and those which do not.
2. Each member of the Trusteeship Council shall designate one specially qualified person to represent it therein.

Functions and Powers

Article 87

The General Assembly and, under its authority, the Trusteeship Council, in carrying out their functions, may:

a. consider reports submitted by the administering authority;

b. accept petitions and examine them in consultation with the administering authority;

c. provide for periodic visits to the respective trust territories at times agreed upon with the administering authority; and

d. take these and other actions in conformity with the terms of the trusteeship agreements.

Article 88

The Trusteeship Council shall formulate a questionnaire on the political, economic, social, and educational advancement of the inhabitants of each trust territory, and the administering authority for each trust territory within the competence of the General Assembly shall make an annual report to the General Assembly upon the basis of such questionnaire.

Voting

Article 89

1. Each member of the Trusteeship Council shall have one vote.

2. Decisions of the Trusteeship Council shall be made by a majority of the members present and voting.

Procedure

Article 90

1. The Trusteeship Council shall adopt its own rules of procedure, including the method of selecting its President.

2. The Trusteeship Council shall meet as required in accordance with its rules, which shall include provision for the convening of meetings on the request of a majority of its members.

Article 91

The Trusteeship Council shall, when appropriate, avail itself of the assistance of the Economic and Social Council and of the specialized agencies in regard to matters with which they are respectively concerned.

CHAPTER XIV

THE INTERNATIONAL COURT OF JUSTICE

Article 92

The International Court of Justice shall be the principal judicial organ of the United Nations. It shall function in accordance with the annexed Statute which is based upon the Statute of the Permanent Court of International Justice and forms an integral part of the present Charter.

Article 93
1. All Members of the United Nations are ipso facto parties to the Statute of the International Court of Justice.

2. A state which is not a Member of the United Nations may become a party to the Statute of the International Court of Justice on conditions to be determined in each case by the General Assembly upon the recommendation of the Security Council.

**Article 94**

1. Each Member of the United Nations undertakes to comply with the decision of the International Court of Justice in any case to which it is a party.

2. If any party to a case fails to perform the obligations incumbent upon it under a judgment rendered by the Court, the other party may have recourse to the Security Council, which may, if it deems necessary, make recommendations or decide upon measures to be taken to give effect to the judgment.

**Article 95**

Nothing in the present Charter shall prevent Members of the United Nations from entrusting the solution of their differences to other tribunals by virtue of agreements already in existence or which may be concluded in the future.

**Article 96**

1. The General Assembly or the Security Council may request the International Court of Justice to give an advisory opinion on any legal question.

2. Other organs of the United Nations and specialized agencies, which may at any time be so authorized by the General Assembly, may also request advisory opinions of the Court on legal questions arising within the scope of their activities.

**CHAPTER XV**

**THE SECRETARIAT**

**Article 97**

The Secretariat shall comprise a Secretary-General and such staff as the Organization may require. The Secretary-General shall be appointed by the General Assembly upon the recommendation of the Security Council. He shall be the chief administrative officer of the Organization.

**Article 98**

The Secretary-General shall act in that capacity in all meetings of the General Assembly, of the Security Council, of the Economic and Social Council, and of the Trusteeship Council, and shall perform such other functions as are entrusted to him by these organs. The Secretary-General shall make an annual report to the General Assembly on the work of the Organization.

**Article 99**

The Secretary-General may bring to the attention of the Security Council any matter which in his opinion may threaten the maintenance of international peace and security.

**Article 100**

1. In the performance of their duties the Secretary-General and the staff shall not seek or receive instructions from any government or from any other authority external to the Organization. They shall refrain from any action which might reflect on their position as international officials responsible only to the Organization.
2. Each Member of the United Nations undertakes to respect the exclusively international character of the responsibilities of the Secretary-General and the staff and not to seek to influence them in the discharge of their responsibilities.

**Article 101**

1. The staff shall be appointed by the Secretary-General under regulations established by the General Assembly.

2. Appropriate staffs shall be permanently assigned to the Economic and Social Council, the Trusteeship Council, and, as required, to other organs of the United Nations. These staffs shall form a part of the Secretariat.

3. The paramount consideration in the employment of the staff and in the determination of the conditions of service shall be the necessity of securing the highest standards of efficiency, competence, and integrity. Due regard shall be paid to the importance of recruiting the staff on as wide a geographical basis as possible.

**CHAPTER XVI**

**MISCELLANEOUS PROVISIONS**

**Article 102**

1. Every treaty and every international agreement entered into by any Member of the United Nations after the present Charter comes into force shall as soon as possible be registered with the Secretariat and published by it.

2. No party to any such treaty or international agreement which has not been registered in accordance with the provisions of paragraph I of this Article may invoke that treaty or agreement before any organ of the United Nations.

**Article 103**

In the event of a conflict between the obligations of the Members of the United Nations under the present Charter and their obligations under any other international agreement, their obligations under the present Charter shall prevail.

**Article 104**

The Organization shall enjoy in the territory of each of its Members such legal capacity as may be necessary for the exercise of its functions and the fulfillment of its purposes.

**Article 105**

1. The Organization shall enjoy in the territory of each of its Members such privileges and immunities as are necessary for the fulfillment of its purposes.

2. Representatives of the Members of the United Nations and officials of the Organization shall similarly enjoy such privileges and immunities as are necessary for the independent exercise of their functions in connection with the Organization.

3. The General Assembly may make recommendations with a view to determining the details of the application of paragraphs 1 and 2 of this Article or may propose conventions to the Members of the United Nations for this purpose.

**CHAPTER XVII**

**TRANSITIONAL SECURITY ARRANGEMENTS**

**Article 106**
Pending the coming into force of such special agreements referred to in Article 43 as in the opinion of the Security Council enable it to begin the exercise of its responsibilities under Article 42, the parties to the Four-Nation Declaration, signed at Moscow October 30, 1943, and France, shall, in accordance with the provisions of paragraph 5 of that Declaration, consult with one another and as occasion requires with other Members of the United Nations with a view to such joint action on behalf of the Organization as may be necessary for the purpose of maintaining international peace and security.

Article 107

Nothing in the present Charter shall invalidate or preclude action, in relation to any state which during the Second World War has been an enemy of any signatory to the present Charter, taken or authorized as a result of that war by the Governments having responsibility for such action.

CHAPTER XVIII

AMENDMENTS

Article 108

Amendments to the present Charter shall come into force for all Members of the United Nations when they have been adopted by a vote of two thirds of the members of the General Assembly and ratified in accordance with their respective constitutional processes by two thirds of the Members of the United Nations, including all the permanent members of the Security Council.

Article 109

1. A General Conference of the Members of the United Nations for the purpose of reviewing the present Charter may be held at a date and place to be fixed by a two-thirds vote of the members of the General Assembly and by a vote of any seven members of the Security Council. Each Member of the United Nations shall have one vote in the conference.

2. Any alteration of the present Charter recommended by a two-thirds vote of the conference shall take effect when ratified in accordance with their respective constitutional processes by two thirds of the Members of the United Nations including all the permanent members of the Security Council.

3. If such a conference has not been held before the tenth annual session of the General Assembly following the coming into force of the present Charter, the proposal to call such a conference shall be placed on the agenda of that session of the General Assembly, and the conference shall be held if so decided by a majority vote of the members of the General Assembly and by a vote of any seven members of the Security Council.

CHAPTER XIX

RATIFICATION AND SIGNATURE

Article 110

1. The present Charter shall be ratified by the signatory states in accordance with their respective constitutional processes.

2. The ratifications shall be deposited with the Government of the United States of America, which shall notify all the signatory states of each deposit as well as the Secretary-General of the Organization when he has been appointed.

3. The present Charter shall come into force upon the deposit of ratifications by the Republic of China, France, the Union of Soviet Socialist Republics, the United Kingdom of Great Britain and Northern Ireland, and the United States of America, and by a majority of the other signatory states. A protocol of the ratifications deposited shall thereupon be drawn up by the
Government of the United States of America which shall communicate copies thereof to all the signatory states.

4. The states signatory to the present Charter which ratify it after it has come into force will become original Members of the United Nations on the date of the deposit of their respective ratifications.

Article 111

The present Charter, of which the Chinese, French, Russian, English, and Spanish texts are equally authentic, shall remain deposited in the archives of the Government of the United States of America. Duly certified copies thereof shall be transmitted by that Government to the Governments of the other signatory states.

IN FAITH WHEREOF the representatives of the Governments of the United Nations have signed the present Charter.

DONE at the city of San Francisco the twenty-sixth day of June, one thousand nine hundred and forty-five.