Syria, Iraq, Ebola, Gaza, Mali – there has been a huge increase in the number of tragic crises in recent months... The humanitarian sector is under enormous pressure. This litany of tragedies is further cause for us to focus on the quality of assistance and protection operations for civilians. It also raises questions about the capacity and role of a sector which remains vital, but is increasingly in danger.

This situation has led to a relatively eclectic issue of Humanitarian Aid on the Move, which covers a broad range of issues. Understanding the importance of IHL, the complexity of situations, and the “turbulence to come” all depends on collective intelligence. Major health risks have emerged in the last ten years. The Ebola crisis shows how our societies have become more vulnerable, but also more reactive. Faced with the risk that it will spread to the rest of the world, our collective capacities will be put to the test.

How do we control this turbulence and violence which seem to be key factors of the future? How do we make societies more resilient, with the redefinition of the Hyogo Framework for Action (Sendai, March 2015) and the COP21 (Paris 2015), where we hope to see a global agreement on the climate? How do we rethink the humanitarian sector of the future, as the World Humanitarian Summit of 2016 invites us to do? The following articles, written by humanitarians and operational researchers, aim to contribute to these global discussions based on field practices and analysis.
Protection has gradually imposed itself as the new paradigm of humanitarian action. Indeed, history has shown that assistance can have a negative impact on people’s right to protection when it is not designed and implemented in the spirit of international law. Non-mandated humanitarian organisations’ lack of direct legal responsibility does not remove their ethical responsibility. On the contrary, it reinforces it. Thus, the bodies responsible for ensuring that human rights treaties are respected, whether at the regional or international level, have gradually sanctioned the horizontal application of certain rights where their violation by a private organisation can lead to the State being held responsible. Eager to fully embrace this ethical responsibility, relief organisations are developing more and more tools to analyse their activity and the design and implementation of their programmes. However, the protective potential of these working methods have not yet been fully used. What is more, the absence of international legal responsibility does not remove the national legal responsibility of organizations and their staff. Over and above their obligation to respect people’s rights as established by the law in the country of operation, we will see that they are also supposed to respect certain rights established by the law in their own country.

The idea of protective humanitarian assistance: the role and responsibilities of non-mandated actors

*Dora Abdelghani-Kot*

The aim of this article is to highlight the substantial role that non-mandated humanitarian organisations play in terms of protection. It points out that the ethical responsibility of humanitarians means that they need to develop relief assistance which takes into account its consequences in the short, medium and long term and places individual rights at the heart of assistance. It also argues that the extraterritorial effect of certain rights means that humanitarian organizations and their staff are legally responsible in several areas of protection. It then presents a certain number of tools developed by humanitarian organizations to ensure that their assistance is increasingly protective and highlights the areas of activity in which improvements still need to be made.

The right to humanitarian assistance and the right to national protection

The right to national protection is much larger than the right to humanitarian assistance, which is the smallest form of protection, the form that is applicable when there is a crisis, when lives are in danger. The right to national protection is defined as the obligation of a State to respect the rights which it has consecrated for the individuals who are under its jurisdiction, in times of peace and in times of war. Though the content of these rights depends to a great extent on the will of the State (and the parties to the conflict), there is a minimum level which is obligatory at all times, that is to say independently of the nature of the context and even outside the ratification of international bodies. The right to life and the right to not be subjected to torture or inhuman or degrading punishments or treatment have, for example, been recognized as non-derogable rights. States and belligerents are under obligation to respect these rights as stipulated by international law: they cannot avoid them and must take all the necessary measures to ensure they are effective. Thus, in order to ensure that civilians are able to meet their basic needs to live in dignity, parties to a conflict cannot arbitrarily refuse foreign humanitarian assistance. However, as the International Court of Justice has stated, in order for assistance to be considered humanitarian, “not only must it be limited to the purposes hallowed in the practice of the Red Cross, namely “to prevent and alleviate human suffering” and “to protect life and health and to ensure respect for the human being”; it must also, and above all, be given without discrimination to all in need.” In underlining the conditions of humanity, impartiality and neutrality, the International Court of Justice is simply reaffirming the spirit of humanitarian assistance: it is not a way of intervening in the internal affairs of a State but a service to be delivered to the parties to a conflict in order to guarantee the basic rights of the people they are responsible for.

In underlining the conditions of humanity, impartiality and neutrality, the International Court of Justice is simply reaffirming the spirit of humanitarian assistance: it is not a way of intervening in the internal affairs of a State but a service to be delivered to the parties to a conflict in order to guarantee the basic rights of the people they are responsible for.
tective function, it should be deployed and used in keeping with the obligations of the parties to a conflict. Emergency relief provided in natural disaster contexts also falls into this legal framework. On this issue, the United Nations General Assembly has stated that humanitarian assistance following natural disasters should be provided in a way that supports national efforts and delivers aid to those in need while ensuring that the programme is carried out in compliance with the principles of humanity, neutrality, impartiality and independence.

Despite this legal framework, there are many examples of crises caused by natural disasters and/or conflicts, where assistance was delivered in a way that was not in keeping with the obligations that apply to those who are supposed to provide protection (States and parties to the conflict). In all these cases, there was an obvious negative effect on people’s right to national protection. The humanitarian response in Sri Lanka in 2009 or in Haiti following the earthquake of 12 January 2010 show that humanitarian action can disempower States, and can even contribute to weakening their capacity to provide those they are responsible for with protection.

The assistance delivered to the Haitian Republic following the earthquake of 12 January 2010 is a symptomatic example of the “collective fantasy of emergency relief”, which encourages humanitarians to act increasingly quickly without taking into consideration the issues involved. Experience has shown that the speed of an emergency response does not mean that the right to humanitarian assistance, that is people’s right to be assisted by their authorities in times of crisis, will be more effectively guaranteed. On the contrary, we have seen that not taking into account the will and capacity of the national authorities to provide relief has direct negative consequences on people’s right to national protection. In the case of the Haitian Republic, a more in-depth analysis of the situation would have shown that the absence of a strong central authority did not mean that there was no capacity and will on the part of certain ministries, local authorities and national civil society organizations. They would have been able to provide part of the response, and more specifically, they would have been more capable of analyzing the situation and establishing relevant and sustainable solutions. What is more, though it has been established that the central Haitian state was partially unable to manage the assistance, the international response should have done everything in its power to reinforce this capacity and encourage national leadership rather than ignore it. Not giving a State the means to fulfil its obligations leads inexorably to greater protection problems. This happened in Haiti due to questionable needs analysis and targeting, as well as persistent difficulties to resolve the crisis due to the lack of will and capacity of the authorities in charge. Certain Haitian intellectuals even stated that the assistance provided was a source of social breakdown and security problems. Similarly, though the humanitarian imperative can justify continuing to send supplies even when there is neither an impartial needs analysis nor the ability to control the distribution of food and non-food items, such a position cannot be justified without the effective empowerment of the state that is affected by the crisis. The response by the humanitarian actors affiliated to the United Nations in Sri Lanka in 2009 was characteristic of this kind of behaviour. The evaluation of the United Nations’ action in Sri Lanka, commissioned by the Secretary General, revealed that the organisation was neither in a position to analyse needs nor to monitor distributions due to governmental obstruction. These clear violations of international law were not condemned (either publicly or privately), the main objective of the organisation having probably been to avoid any confrontation with the government. However, this lack of confrontation and insistence that the State fulfil its obligations led to a large number of violations of people’s basic rights.

Situations like these in which assistance supplanted protection remind us that the humanitarian nature of a programme is as much a question of ends as it is of means. Indeed, the main aim of humanitarian action should be to establish the right to national protection and, consequently, the means used should be adapted to this aim. In other terms, humanitarian action should contribute to making the State accountable as well as reinforcing its protection capacity. Contrary to what we might think, public denunciation is not the main tool to achieve this objective, and a broad pallet of methods can be used in aiming to contribute to greater protection.

Organisations’ ethical responsibility

In operational terms, respecting the humanitarian nature of assistance means that non-mandated humanitarian actors have an ethical responsibility in the area of protection. In this regard, the initiatives undertaken by numerous NGOs and certain United Nations agencies, show that the challenges encountered in crisis contexts do not constitute an insurmountable obstacle to the adoption of ethically responsible measures, in relation to providing people with more protective assistance. These measures are substantially based on the “Do no harm” approach, which involves carrying out a holistic analysis of crisis situations in order to improve understanding of the issues at stake and anticipate the consequences of foreign humanitarian assistance. In this respect, several codes of conduct and standards have gradually been developed by NGOs and the United Nations. However, as the French Human Rights Consultative Committee pointed out, certain approaches bring the risk of standardization, directly challenging the diversity of operational contexts. Though the humanitarian ethic is essential, it has to be adapted to each context. What is more, the “Do no harm” approach...
also leads to an acceptance of the limits of humanitarian action, thus encouraging organizations, whether mandated or not in terms of protection, to invest more in sector-based coordination in order to ensure that initiatives are complementary. The main objective of the Cluster approach, which was introduced by the Humanitarian Reform of 2005, is to improve humanitarian action with the aim of providing communities with greater protection. The idea is to develop a more structured, accountable and professional humanitarian community in order to be a better partner for governments, local authorities, local civil society and affected communities. Humanitarians agreed on the need to place protection at the heart of the coordination mechanism by giving the Protection Cluster a strategic role, having to ensure that “the assistance is delivered in a way that has a positive impact on protection”\textsuperscript{21}. This has not yet had as much effect as had been hoped because the capacity of the Cluster depends to a great extent on external factors. For example, when there is no engagement on the part of the humanitarian coordinator in favour of protection, the Protection Cluster’s capacity for action is substantially reduced\textsuperscript{22}. Addressing the question of humanitarian assistance from the angle of people’s rights constitutes a complementary method which helps to guide choices about forms of action as well as the nature and method of assistance programme implementation. This approach places individuals affected by disasters and conflicts at the centre of humanitarian action, as well as the responsibility of their States to protect them. What is more, it roots humanitarian action in universal principles, such as human dignity and non-discrimination. In doing so, it guides humanitarian action towards the development of programmes whose first objective is to respect the rights of individuals and to strengthen the capacity of national actors, which is a prerequisite for achieving the sustainable protection of communities. This method also leads to the protection of those who have special protection rights such as women, children, the handicapped and the elderly: it is what has been called the age, gender and diversity-based approach, which guarantees a needs analysis and response which is in keeping with legal requirements. The participatory and community approach is part of the same framework. Indeed, people’s participation in the decisions that concern them is one of the basic principles of human rights.

The limited legal responsibility of humanitarian organisations

Translating the ethical responsibility of humanitarians into legal terms is not easy\textsuperscript{23}. Indeed, the idea that non-mandated organisations are accountable to the population should not lead to the reversal of responsibilities in terms of humanitarian action and protection. Only States have the legal obligation to protect the people under their jurisdiction and therefore the obligation to provide them with assistance. At the same time, non-State actors do still have legal responsibilities in the humanitarian field. This is not the place to go into any detail about issues related to the responsibility of United Nations agencies and their staff\textsuperscript{24}. On the other hand, if we look at the responsibilities of French NGOs in their broad lines, this illustrates the extra-territorial effect of certain rights\textsuperscript{25}.

During an operation on foreign soil, French NGOs, and their members of staff, can be held responsible not only for violations of the law in the crisis-affected country, but also for the violation of certain rights which are recognized by the French legal system. For example, under criminal law, offences by legal or private persons in a foreign territory are punishable in France when they represent a crime or misdemeanour\textsuperscript{26}. It is interesting in this context to remember that all involuntary violations of the lives or physical integrity of individuals constitute misdemeanours\textsuperscript{27}. Though a number of humanitarian programmes have been implemented with the aim of guaranteeing the physical security of individuals, whether beneficiaries or staff of organizations\textsuperscript{28}, the legal obligation to prevent involuntary violations of people’s lives or physical integrity makes it possible to extend the benefit of these measures to partners whose security is sometimes not sufficiently taken into consideration\textsuperscript{29}. Rape and sexual assault of majors and minors, and sexual abuse of minors committed with their consent are considered to be crimes in France\textsuperscript{30}. Though humanitarian actors try hard to prevent and deal with sexual abuse and exploitation by their members of staff, in practice they still have great difficulty in managing these situations. Impunity due in part to the lack of operational policies and procedures does not improve the lot of victims. More effort is needed in order to ensure that this behaviour is the object of criminal procedures. Developing coordination and cooperation between different human resource departments would be very useful in this area.

It is now generally accepted that humanitarian actors should provide protection based on people’s rights. As we have seen, NGOs and the United Nations have formally committed themselves to this and are gradually developing a number of ways of achieving this common goal.
These efforts should be reinforced and we believe that the system for coordinating humanitarian action which has been in place since 2005 will be an effective tool for achieving this objective if the different actors manage to use it to its full potential. Guided by the “Do no harm” approach and adopting a vision of humanitarian action based on rights, this information exchange and coordination platform will be in the best position to reduce people’s vulnerability and ensure that an effective response will be implemented if their rights are violated. Though it is obvious that humanitarians will never be able to avoid all the risks of abuses inherent to the contexts in which they operate, and that the success of protection depends on the capacity and will of States and their populations, they are still bound to take all the necessary measures to make sure assistance is provided in keeping with the law. Only this kind of humanitarian assistance will allow links to be established between relief, rehabilitation and development by strengthening the will and the capacity of national actors to prevent violations and, to a certain extent, to repair the consequences. Finally, though NGOs do have legal responsibility, this is not related to the provision of assistance or to quality standards. As we have seen, humanitarians need to develop more consultation, coordination and exchange about how to prevent and repair involuntary and voluntary violations of people’s security and physical integrity, whether this is linked to the behaviour of particular humanitarian workers or the implementation of assistance programmes. Integrating a protection approach into humanitarian activities is simply a way of meeting demands in terms of legality, legitimacy and the quality of emergency assistance. This approach is a genuine strategy which aims to complement and especially reinforce the work of organisations responsible for protection by placing people and their rights at the heart of humanitarian action. Though NGOs and the United Nations have made a great deal of effort in recent years to provide people with greater protection, there is still room for improvement.

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2 In connection with non-international armed conflicts, the national right to protection also includes the obligation for belligerents to respect the rules of International Humanitarian Law which considers that because they take part in the fighting, the belligerents have power over the lives of the civilian population and therefore are consequently under the obligation to provide protection. As stated in article 3 which is common to the four Geneva Conventions, this obligation which is incumbent upon non-state entities does not affect their legal status. According to a basic principle of IHL, all belligerents are bound by the same obligations. International Conference of the Red Cross and Red Crescent, International Humanitarian Law and the challenges of contemporary armed conflicts, October 2011, https://www.icrc.org/eng/assets/files/red-cross-crescent-movement/31st-international-conference-ihl-challenges-report-15-5-1-en.pdf p. 30. Also, as private individuals who are subject to the jurisdiction of a state, belligerents are obliged to respect rights which have been established nationally notably with regard to violence towards life and physical integrity.

3 As stated by the International Court of Justice, these standards are based on elementary considerations of humanity and the obligation to respect them comes not only from the Conventions but also from the general principles of law, of which the Conventions are only a concrete expression. “Case concerning military and paramilitary activities in and against Nicaragua”, International Court of Justice, Judgement of merit, 27 June 1986, §215, 218, 219, 220, http://www.icj-cij.org/doc.asp?lang=En&public=1&nc=2602.

4 In a crisis context, the right to life is always weighed against the need to maintain public order and/or to guarantee the national security of the state. The arbitrary nature of the violation is analysed on the basis of this relationship of proportionality. See the Twenty-first International Conference of the Red Cross and Red Crescent, “International Humanitarian Law and the challenges of contemporary armed conflicts”, op. cit., p.22. In relation to the right to humanitarian assistance, see “L’assistance humanitaire face à la souveraineté des États”, Olivier Corten and Pierre Klein, https://dipot.ulb.ac.be/DSpace/bitstream/2013/36247/1/1992.Assistancehumanitaire.pdf.

5 “Case concerning military and paramilitary activities in and against Nicaragua”, op. cit., §243.

6 See also the resolutions of UN General Assembly establishing the regulatory framework for humanitarian action, United Nations General Assembly Resolution 46/182 from 1991 and 58/114 from 2004.

7 Resolution 68/103 of the UNGA: International cooperation on humanitarian assistance in the field of natural disasters, from relief to development specific to humanitarian action in natural disaster contexts, 2013, §18. See also the work of the International Law Commission on the drafting of an agreement on The Protection of Persons in the event of Disasters and all the reports on the question written by Special Rapporteurs at http://www.un.org/law/icel.

8 United Nations General Assembly, Resolution 68/103, op.cit., §24


10 Ibid.

11 In Haiti, public agents were too often excluded from the collective emergency response. See, for example, Does humanitarian coordination exclude local actors and weaken their capacity?, Andréanne Martel (http://www.wro.org/Does-humanitarians-coordination).


13 Public denunciation is not necessarily the best way of achieving accountability. In each context, humanitarian actors should ask themselves if it is an effective way of achieving accountability. In any case, it should only be used impartially as a last resort, and as far as possible with the enlightened consent of the population. See for example, “Increasing respect for IHL in NIACs”, ICRC, 2008, https://www.icrc.org/eng/assets/files/other/icrc_002_0923.pdf. NGOs’ capacity to question the responsible authorities (the state in crisis, the belligerents and also states in general who are supposed to respect and enforce these regulations which could bind their actions) should be developed.


15 Ibid. §46.
Working in a prison for a humanitarian organisation is not easy, particularly because of the specific characteristics of such places. Médecins Sans Frontières’ experience working in Insein prison illustrates the difficulties of achieving objectives both in terms of results (long term provision of appropriate and full medical care to patients) and working conditions (minimal manipulation, indiscriminate access to patients, etc.).

There is not a lot of literature about humanitarian action in prisons, which tends to imply that it is not very common: not all NGOs who want to work in prisons are able to and, in theory, information about what happens inside is not available to the public.

The situation is paradoxical, with prisoners among the least susceptible to be provided with external aid when this is needed.

Excluded from society for what they have done or what they think, prisoners’ well-being is totally dependent on the goodwill of the authorities. If there is a disastrous health situation, this is often the result of voluntary negligence: security is the main, if not only, preoccupation of the authorities. Providing basic services such as food, hygiene, health and protecting prisoners’ rights, in a way that guarantees dignity, is of secondary importance, as was reported by Manfred Nowak in 2010 (who was the UN Special Rapporteur on torture at the time), after four years spent visiting a large number of prisons throughout the world.

One of the reasons that there are so few assistance projects in prisons is no doubt the difficulties linked to the conditions in which action can take place: what can be done in a prison depends completely on the authorities and this is either imposed by them or is the object of very tough negotiations. Indeed, all the problems which can exist in any humanitarian project can also exist in prison, but more intensely than elsewhere (risks of manipulation, of collusion, of a lack of implication by the beneficiaries, violation of independence and impartiality, security problems, etc.).

Médecins Sans Frontières (MSF) has some experience of working in prisons bringing vital assistance to inmates in response to a medical emergency (cholera, famine, etc.). Sometimes the organisation takes the initiative of proposing a healthcare programme for inmates with a chronic disease who have not had access to full healthcare from the authorities in charge (tuberculosis, AIDS, etc.). These cases involve longer-term programmes to deal with these public health problems.

MSF’s experience in Myanmar is an example of this type of situation and the difficulties of achieving objectives both in terms of results (patients being provided with appropriate and full healthcare in the long term) and working conditions (minimal manipulation, indiscriminate access to patients in need...).
A rare opportunity

Acting as a humanitarian organisation in Myanmar is very complicated. Though the situation in 2014 has somewhat evolved, when discussions began about the possibility of MSF working in prisons (2008), there was a lack of trust between humanitarian organisations and the Burmese authorities: the regime, which was known to be one of the toughest in the world until the dissolution of the junta in 2011, was not at all happy about foreign humanitarian action, particularly in the most sensitive regions.

Humanitarian needs existed (conflict, poverty, poor health services, climatic hazards, etc.), but the working conditions that were imposed made it very difficult: administrative barriers and complications; access to conflict zones in the East of the country was virtually impossible; discussions with the authorities were filtered by spokespersons from the Ministries who did not have any decision-making power; prohibitive taxes on imports; attempts to control the local staff which led to endless negotiations and uncertain results; funding which was difficult to obtain from funding agencies, etc.

In addition to this, we should also mention the very strong suspicion which was felt, at the time, by the Burmese opposition in exile and in prison, as well as by certain campaigners around the world, who accused aid organisations of playing into the hands of the dictatorship by taking action in Myanmar.

The authorities had full power over humanitarian action, without the criteria for decisions always being clear or understandable for aid organisations. As a consequence, the need to accept compromises (some would say the sacrificing of principles) often led to very heated debates within humanitarian organisations.

In 2008 the Swiss office of MSF in Yangon was unofficially approached, in an unofficial capacity, to work in Insein prison: Myanmar’s “silent killing field”. Someone who had formerly been in charge of prisoners’ health contacted MSF to develop an AIDS programme for prisons. Up till then, nothing had been done for infected patients. This person had already seen and appreciated AIDS programmes run by MSF in different regions of the country. According to the information we obtained, it was the deaths of political prisoners with AIDS that pushed the leaders of the junta to demand that something was done so that this did not happen again.

No foreign organisation had worked in prisons since 2005.

Medical data supplied by the Burmese authorities showed that AIDS and TB were the most common causes of mortality in prisons (27% of deaths in Insein prison in 2008 were related to AIDS) even though the number of deaths had already fallen since the national programme against TB had begun to detect and provide treatment to patients with pulmonary TB.

Insein prison, the biggest in the country, had between 6 000 and 8 000 prisoners, some of whom were only in transit, during their trial or before being transferred to a work camp. In addition, 1/5 of the prisoners were women. According to the figures provided by the authorities, 30% of female prisoners who had worked in the sex industry had AIDS (compared to 0.67% of the country’s population as a whole). And the number of cases of TB was 25 times higher in prison than in the population as a whole (according to the World Health Organisation, there were 525 cases for every 100 000 people in the general population).

A period of discussion and negotiation

At Médecins Sans Frontières, there were very heated discussions about whether or not to seize this opportunity: should we, on principle, accept to collaborate with a dictatorship to assist a population, who clearly had needs, but whose well-being was exclusively the responsibility of the authorities? Would we help patients to get back on their feet only for the system to knock them back down again? Could we refuse to assist people living in deplorable conditions, in terms of health amongst other things, when MSF was created “to go where nobody else goes”? Should we not try to provide assistance with the risk that we might quickly give up (and perhaps denounce an unacceptable situation)?

The decision was made to begin negotiations while giving ourselves all the time that was needed to achieve acceptable conditions for the project.

During the negotiation phase, MSF engaged in discussions internally about the conditions that needed to be met before we would consider going ahead with the programme. As a result, we established a kind of management chart which would help those in charge of the project to closely monitor the development of the negotiations and activities.

The preconditions for launching and pursuing activities concerned three areas:

1) In terms of security:
MSF refused to allow the presence of arms or any means of restraint in its clinic. MSF staff, to be chosen by the organisation alone, were not to be threatened or forced to take part in acts which would be harmful for the health or well-being of the patients. Access to the clinic was to be
guaranteed to MSF staff, whether foreign or Burmese. Patients were to have unrestricted and voluntary access to the MSF clinic (common law prisoners and prisoners of conscience) based on their need for treatment as determined by the MSF staff or at the request of the patient if there was a problem.

2) In terms of healthcare procedures and protocols:
The protocols were to be based on MSF’s quality criteria. Patient consultations were to be strictly confidential (consultation rooms and medical data). If necessary, patients could be referred to specialist institutions.

3) In terms of project strategy:
MSF would provide the prison authorities with support for a period of five years, if, during this period, the authorities demonstrated the will to invest in prisoners’ health beyond AIDS in the form of shared management. This period was deemed to be long enough for capacity building and skills transfer before MSF withdrew. MSF, for its part, made a commitment to find the human and material resources necessary and guaranteed that it would supply antiretroviral (ARV) and other medicine for patients receiving treatment, up to a year after the withdrawal of the organisation, regardless of the reasons.

To maximise the chances of success of this observation phase, Médecins Sans Frontières decided not to publicise the negotiations or the possible launch of this new activity. Contacts were nevertheless established with the diaspora to find out how medical work by MSF in a Burmese prison might be perceived.

Two years of negotiations were needed before the two parties felt sufficiently comfortable and MSF’s activities started in the prison.

Implementation under strict surveillance

A letter of agreement was signed in August 2010 between the prison authorities and Médecins Sans Frontières which allowed collaboration to begin, treating prisoners with AIDS. The letter specified that if the collaboration was fruitful, other medical treatment could then be provided by MSF.

Both parties observed and tested each other during the launch phase of the activities which began concretely at the end of 2010. MSF staff provided the 140 prisoners who had been referred by the prison’s medical services with treatment in the MSF clinic which was set up just outside the prison (140 was the number of prisoners mentioned in the letter of agreement).

Conscious of the dangers of its activities being manipulated, MSF adopted a special monitoring regime to monitor activities and negotiations in order to react immediately to any problems that were encountered: management chart of indicators related to working conditions; discussion group including experienced people who were not linked to the running of the project, to regularly review how the negotiations were progressing; annual visit of the project, etc.

MSF saw the first year as a pilot phase which would ideally lead to AIDS treatment being integrated into the prison’s general healthcare services and genuine co-management of healthcare.

Results

During the three years of collaboration, MSF staff achieved some very positive results:

- 1 401 patients (15 188 consultations in total) received treatment from MSF, 448 of whom received ARV treatment in satisfactory working conditions. What is more, the authorities accepted and respected MSF’s preconditions during the whole period in terms of treatment protocols, access and security.

- In terms of mortality, whereas 49 deaths were recorded as being caused by AIDS in 2010, there were 23 in 2011, 12 in 2012 and 19 in 2013. The deaths often took place when patients were referred to MSF when the disease was in a very advanced stage.

In addition to the medical and psychological consultations related to AIDS, MSF was in charge of opportunistic diseases, other sexually transmitted diseases, vaccinations (including hepatitis) and referrals to specialist services and hospitalisations.

Viewed positively by the patients who received treatment, the MSF staff never heard any stories of violence carried out by the prison staff against one or more prisoners.

The relations between MSF staff and the prison authorities were cordial, and the coordination meetings to monitor and manage the problems which arose regularly, proved to be effective. To illustrate this, we will now look at examples of problems that were dealt with: discrimination against AIDS patients; and providing treatment to patients who had been released from prison and patients who were from other prisons in Myanmar.

Very quickly, the patients who were seen by MSF were subjected to certain forms of discrimination by other prisoners and prison staff because they were identified as carriers of the AIDS virus: everyday tasks were imposed or refused, and they were subjected to baiting and insults.

Having been informed of this, the prison authorities helped change this behaviour. Cells were opened for prisoners with AIDS. This measure was imposed by the prison authorities and was appreciated by the patients. Once they were stabilised, the patients were able to go back to their shared cells. Awareness-raising sessions for the prison’s medical and security staff helped to stop the discrimination.

Contrary to received wisdom, prisons are open spaces, in the sense that most prisoners end up leaving: either
because they have served their sentence or because they have been granted amnesty. Through negotiation, the MSF staff were able to get advance notification of the prisoner-patients who were going to be released. Through links with medical structures who were able to provide these patients with care in their home region (national and international NGOs and the Ministry of Health), 86% of the prisoners who were released were successfully referred.

At one point, the MSF staff realised that the prisoners who were sent to their clinic were from other prisons in the country, without MSF knowing on what basis these transfers were made (in exchange for money?), and without being able to follow up these patients. Faced with the risk of becoming the auxiliary of the whole Burmese prison system, and with negotiations still underway to establish the limits of each party’s responsibilities, MSF decided to oppose this trend through negotiation (from the moment MSF announced its withdrawal, the organisation no longer had any control over this. In total, 25% of the people who died among the large number of people treated by MSF staff came from other prisons than Insein, where no treatment or care for AIDS was available). However, MSF successfully campaigned for women imprisoned for prostitution and who were HIV positive to be able to stay in a rehabilitation centre for a return to civilian life, where living conditions were much better, rather than going to Insein. In the end, the Ministry of Health accepted to put in place healthcare for the disease in this rehabilitation centre.

**Dilemmas and decisions**

All this progress did not allow three conditions to be met that had become essential in MSF’s view for the collaboration to continue: indiscriminate access by MSF to all prisoners who needed medical care, the early detection of patients with HIV and a real investment by the prison authorities in order to be able, eventually, to totally fulfil their responsibilities with regard to the health of the prison population.

Ethically speaking, it was becoming increasingly unbearable to know that though the prisoners who were referred to MSF by the authorities had the right to a quality service, all the other prisoners had to go through the prison healthcare system, which was known to be very limited. The negotiations which began at the end of the first year of the project (end of 2011), discussions between MSF and the prison administration focused on opening a new phase of partnership for the benefit of the prisoners, any proposals that were made with precise content and duration were rejected. So too was real investment by the authorities to allow them to eventually take on MSF’s responsibilities.

In June 2012, a cholera epidemic broke out in the prison. Officially, around 450 patients and members of the prison staff were infected. Fortunately there was only one death. Despite unofficial requests by prison staff and managers to receive assistance from MSF, all offers of services from the organisation were officially rejected. This was further confirmation that the collaboration, from the point of view of the authorities, was just a ‘sub-contracting of services to an external actor kept on the outside...

One of the biggest problems that came up in terms of effectively treating patients with AIDS was the late detection of cases, who were usually referred when the disease was in an advanced state. Tests were carried out by the prison health staff, in ethically and qualitatively questionable conditions. Médecins Sans Frontières’ proposal to share responsibility for carrying out HIV tests to MSF, in the MSF clinic, for all new prisoners that they referred.

Though, from the end of the first year of the project (end of 2011), discussions between MSF and the prison administration focused on opening a new phase of partnership for the benefit of the prisoners, any proposals that were made with precise content and duration were rejected. So too was real investment by the authorities to allow them to eventually take on MSF’s responsibilities.

Clearly, and in an increasingly official way, the objectives and limits of the partners became clearer... and contradictory. The Burmese prison system was not planning to begin providing healthcare for AIDS in prisons and was only looking to outsource this activity to an external partner.

In June 2013, after more than a year of negotiations, MSF officially decided to withdraw from the programme, giving the authorities six months to develop their action plan for the future. Rapidly, an international NGO (The Union) stated that it was interested in taking over MSF’s activities on the terms imposed by the authorities. The handover therefore went as well as could be hoped.

**What lessons have been learned?**

Independently of the success of having treated all the patients provided with healthcare by Médecins Sans Frontières and now by another organisation, as well as all the experience acquired by the organisation and its staff in...
working in a prison environment, questions remain and the answers might be different from one organisation to another:

Should a programme have been started without all the conditions having been fixed and codified in advance in a full agreement to which both parties were tied?

For MSF, the question of the long-term sustainability of an operation or the guarantee of success are not prerequisites before launching an operation. In this case, it was decided that the conditions for beginning a medical programme had been met (pilot phase limited to providing healthcare for AIDS patients, while being open about the objective of running a global project in due form).

Without doubt, in Myanmar perhaps more than anywhere else, negotiating the conditions of a programme in a priority niche (in which existing experience and expertise could be replicated in other similar contexts)

Is it possible to anticipate and manage the problems and risks of being manipulated when a programme takes place at the heart of a repressive dictatorial regime?

Unless we consider that prisoners do not deserve to receive aid like any other human being, it is natural to envisage a project that responds to recognised needs. For Médecins Sans Frontières, the unacceptable level of mortality related to AIDS fully justified the operation: the cost-benefit ratio clearly leaned towards launching the project.

At the same time, the characteristics of the prison environment, regardless of the country, mean that a specific kind of monitoring (of procedures and resources) is necessary for this type of project: there are genuine risks of manipulation and participation in the repression of prisoners – even if this is involuntary.

The specific tools that were used by MSF for the Insein project were not particularly complicated, and could easily be replicated in other similar contexts.

Can a humanitarian organisation, which conducts programmes which have a limited timescale, try to reform the healthcare provided to AIDS patients in a prison environment (what is more, in Myanmar)?

In the end, the issue which caused the most controversy within the organisation itself was the objective of structural change in the quality of healthcare provision to the prisoners via a short-term project in a prison. Time is a major factor of success: beyond the slogan, “we cannot know until we have tried”, which is debatable but is used, it was very important for such a difficult project that the objectives of the project should have been compatible with the time given to achieve them.

In this case, there were clear difficulties in establishing working relations between foreign actors and the Burmese authorities and in understanding the reasons why a request was refused or accepted. Other characteristics, however, provided a counterweight to these unfavourable factors: the request for action came from the Burmese authorities themselves. What is more, they have begun to include the treatment of AIDS in their healthcare provision for people outside the prison system and Insein has the infrastructure and medical staff that are needed.

The fact that Médecins sans Frontières’ initial action took the form of a pilot phase which only addressed AIDS cases may have had an ambivalent impact: it allowed MSF to immediately be effective for the patients while respecting the conditions of the collaboration with a view to greater investment, but it deprived MSF of a major asset in the negotiations for a global health project: the authorities’ initial request – the provision of healthcare to patients with AIDS, was immediately satisfied. Why would they then accept broader collaboration? MSF felt that it was worth the risk...

No doubt Médecins Sans Frontières will run projects in prisons again in the future, given the enormous needs and the limited number of organisations who are willing or able to do this kind of work. The direct impact in terms of mortality will certainly be a major criterion behind the decision to act. Nevertheless, experience shows that the conditions in which the project are to be implemented need to be analysed in detail and sufficient time needs to be taken to make an informed decision.

Beyond MSF’s involvement in the future, given the specific characteristics and challenges of prison environments, humanitarian and medical operations in prisons could become a domain (or niche) in which existing experience and expertise could be brought together in a specific type of service. This could be developed within an organisation which is already active (MSF or other), or via the creation of a new organisation.

Jean-Marc Biquet
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1 “…I got a fairly comprehensive impression of the conditions of detention around the world. In many countries I was simply shocked by the way human beings are treated in detention. As soon as they are behind bars, detainees lose most of their human rights and often are simply forgotten by the outside world” Extract from the Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment” of 5/2/2010,
Point of view

Problems of quality in humanitarian action: what exactly are we talking about?

On 15, 16 and 17 September 2014, at Groupe URD headquarters, the Autumn School on Humanitarian Aid brought together specialists on issues of Quality and Accountability. Much is happening in this area, with two important projects being presented in Copenhagen on 12 December 2014: the Core Humanitarian Standard, which has been developed due to the need for greater coherence between the various standards that exist, and the results of the Certification Project led by the Steering Committee for Humanitarian Response.

The key points of the Autumn School will be published on Groupe URD’s website in October. The aim of this article is not to give a detailed account of the very rich discussions which took place, but rather to talk about a specific issue which was a common theme throughout the discussions: what is the fundamental nature of the problems of quality in the humanitarian system? And to give Groupe URD’s point of view on these questions.

Different definitions of quality depending on points of view

Agreeing on a definition of quality is not easy in any sector of activity. It is essentially made up of very subjective characteristics and has very different meanings depending on the point of view of the people involved. Attempting to define quality for humanitarian aid, a very complex and multi-party sector, is extremely difficult. At one end of the chain, the people affected by disasters mainly need to have access to assistance which is adapted to their situation and their priorities and which is delivered in a timely manner. At the other end of the chain, donors of course want to satisfy these basic needs, but they also have a lot of other pre-occupations such as obeying the policy directives of their governments, ensuring that their operational partners respect administrative and financial regulations, and checking their activities in the field. These additional imperatives come from the donor’s role in managing public funds and the strong legal constraint in relation to public opinion which comes from having to justify how funds have been spent and what effect this has had.

Each stakeholder in the aid system – affected communities and people, local and national authorities, individual donors, operators, etc. – therefore has their own idea of what a good quality humanitarian operation should be. These different perspectives are also present within humanitarian organizations who have an obligation both to satisfy the demands of those who fund them and to respond to the needs of disaster-affected people. Tension is common within organizations between, on the one hand, the management who want to consolidate the structure by satisfying and reassuring the funding agencies, individual donors and the media, and on the other hand, the operational staff who are in contact with the affected people, who are more concerned about the quality and relevance of the operations in the field.

One specific characteristic of the sector comes from the fact that the international aid system is not structured in a way that gives the “beneficiaries” control over the organizations who provide them with assistance. This is a fun-
Humanitarian Aid on the move

Review n°14

Dental difference with the private sector where quality management principles were developed. In the private sector “the customer is king”: he can choose his supplier and then boycott him or damage his reputation if he is not satisfied with the service that has been provided. Customer satisfaction is central to private sector quality approaches. Though it is important to be careful about comparisons between the private sector and the humanitarian sector due to the differences in their ethical foundations, it is nevertheless true that aid “beneficiaries” currently do not have a great deal of power over the aid system.

Different perceptions of quality issues

These specific characteristics of the humanitarian sector therefore naturally lead to different ways of interpreting problems of quality depending on who we speak to in the sector. The Autumn School on Humanitarian Aid revealed different points of view which show the need to change the sector’s quality and accountability mechanisms and tools.

The emergence of new actors

Without doubt, one of the motivations behind the certification project has been the emergence of non-professional organisations in contexts which have received a lot of media coverage (e.g. the 2004 Tsunami and Haiti en 2010). The media, who are often looking for scandal, have reported on the actions of these organisations, and there have been repercussions for the humanitarian community as a whole.

On a more subtle level, the increase in the number of aid organisations due to the rise of businesses, military bodies and national actors like the National Disaster Management Agencies (NDMAs) during the response to a crisis raises the issue of criteria and the principles which define humanitarian action. Should the implementation of the Core Humanitarian Standard (CHS) allow the integration of these organizations, or on the contrary, should it preserve “traditional” humanitarian space? This is one of the underlying issues and one of the major difficulties in trying to develop a definition of aid quality.

The national authorities, who generally have some marginal involvement in humanitarian operations, can make access to operational areas and the implementation of programmes more difficult. The CHS and certification projects can also be seen as the establishment of guarantees which will make access easier for professional organizations in the event of a disaster...

It is this change in the number and nature of operational organisations in crisis contexts which, to some extent, has motivated the efforts to define quality and regulation in the sector, with the perhaps contradictory objective of both including certain organizations and excluding others.

A crisis of confidence with public opinion and the media

At the same time as this change in the institutional landscape has taken place, there has also been a “crisis of confidence” between donors (influenced by the media), local authorities (who want a more important role) and traditional humanitarian organizations.

But this crisis of confidence is also due to the way that organizations tend to communicate about their activities without mentioning the real challenges and difficulties of operations in the field in favour of a more simplistic image which aims to motivate donations and reassure the donor. This type of communication creates high expectations on the part of public opinion and contributes to the criticism of the humanitarian sector relayed by the media when the sector fails to meet these expectations.

This phenomenon is amplified by the increased competition between humanitarian organisations and the increasing need to retain donors by appearing in their best light in the media. From this perspective, all efforts to increase quality and accountability should include information (rather than communication) aimed at the media and the public about the reality of programmes in the field, including their limits and the difficulties encountered.

Donor demands and needs

The main donors who have been around for a long time such as ECHO, USAID and DFID have been able to develop expertise and a strong field presence. This maturity and the related resources allow them to maintain relations of trust with their implementing partners and to work in close collaboration with them on the problems involved in humanitarian operations. But not all humanitarian sector donors have this kind of capacity, whether we are referring to small donors from emerging nations or private donors like foundations. For them, the question is how to guarantee that their implementing partners are viable and that the operations carried out in the field in their name are of good quality. The certification project could be useful for donors with more limited capacity who would therefore delegate to a third party some of the work involved in checking that organizations meet standards.
There is currently an imbalance in the humanitarian system with an enormous amount of energy and resources spent on audits and reporting. This very large amount of bureaucracy mainly directed at legal and financial aspects diverts resources from the issues which genuinely impact the quality of the service delivered to communities. However, it seems unlikely that in the short term certification would lighten the many demands of funding agencies, who are themselves restricted by their own accountability mechanisms. The question of the imbalance between the quality of programmes and the quality of reporting remains.

The quality of programmes

It has been said that the sector-based humanitarian system is perhaps not capable of providing quality from the point of view of beneficiaries; a system which is split into operational sectors and population groups which follows the priorities of the sector and different specialisations (WASH, Nutrition, Food Security, Shelter, IDPs, Refugees, etc.) does not correspond to the reality and everyday lives of people in crisis situations whose needs are interconnected.

As people affected by disasters have very limited means to give their opinion about aid quality, it is difficult to systematically measure the reality of the problems that exist. The development of new communication technologies could have a major impact in the future on this issue, by encouraging short supply channels for aid and feedback mechanisms (via SMS, email, etc.).

In the end, the central question of the quality of programmes remains. At the Autumn School we did not manage to achieve a consensus about the reality and the seriousness of problems of quality in humanitarian operations. In particular, the professional NGOs who were present were eager to underline the substantial progress that has been made in recent years, while recognizing that there was obviously still room for improvement.

Conclusion

It seems unrealistic to imagine that one or two initiatives will allow all quality problems to be solved. The humanitarian system is chaotic, made up of a variety of bodies and based on a systemic logic. There is no lever to pull, or magic solution, to solve all the problems of quality. Faced with each problem, the aim is to identify specific and complementary ideas for action to improve effectiveness at the global level.

So, for example, concerted advocacy on the part of NGOs aimed at funding agencies to lighten the reporting load, in keeping with the commitments the very same funding agencies made in connection with the Good Humanitarian Donorship initiative, seems necessary. This would probably help to improve the balance between the relative importance of whether administrative and financial standards are respected in favour of monitoring the quality of programmes from the point of view of the beneficiaries.

What is more, a change in the type of communication with the media and the general public would probably help to re-establish confidence in professional organisations. This could be done, for example, through more systematic sharing of evaluation results or more collective fund-raising mechanisms to avoid media-based one-upmanship.

With regard to the emergence of non-professional organizations in contexts which receive a lot of media coverage, it seems unrealistic to think that a certification mechanism would put an end to their activities because, by definition, these organizations are situated “outside the sector”... On the other hand, educating the public about donorship and solidarity in our own societies would help to spread ideas about what is useful when there is a disaster, what is not useful and what operational constraints there are in these contexts.

Lastly, over and above the different solutions that have been outlined and alongside the evaluation culture which currently exists in the sector, a cultural revolution in Quality at the institutional level still needs to take place. Organizations would then be engaged in a process of continual improvement. Studies about quality in other sectors of activity systematically estimate the cost of non-quality to be between 15 and 25% of the turnover in an organisation which has not implemented a quality approach. It was this calculation of non-Quality which led to the revolution in other sectors. In the humanitarian sector, these costs are currently carried by the affected populations and are not calculated in financial terms but in added suffering, in time lost, in useless frustration, etc. Therefore, for the time being, it remains an ethical responsibility and a voluntary decision on the part of professional organisations to put in place effective, long-term continual improvement mechanisms... until relatively structured feedback systems emerge, based on new communication technologies, and which may well disrupt the balance of power between organizations, communities and donors.

Julien Carlier - Quality Advisor, Groupe URD
Véronique de Geoffroy - Director of Operations, Groupe URD
With an increase in the average temperature of 1°C during the last century, radical changes are beginning to be observed. The planet is faced with more and more devastating events which do not correspond to the statistical data of the past. The increasingly frequent waves of drought which regularly affect the Horn of Africa, the Sahel, Australia and the Southern coast of the United States, and which are often accompanied by large scale forest fires; cyclones or torrential rain which regularly affects the tropics; devastating tornadoes in the United States; and floods in Europe, and notably the South-East of France, are there to remind us both of our vulnerability to extreme climatic phenomena and the weakness of our predictive models in relation to the unknown.

The many methodological precautions which exist (see table below) remind us that the more extreme and therefore rare an event is, the less data there is about it, and consequently the more difficult to construct models based on historical frequency of occurrence.

Though nothing is definite, the perspectives are more than worrying. Studies on civilizations which have disappeared (Mayan, Khmer, etc.) conducted by archaeologists, some with support from NASA, and brilliantly summarized in Collapse: How Societies Choose to Fail or Survive, are sometimes seen as the flights of fancy of researchers, or even science-fiction. They are nevertheless "whistleblowers".

Faced with all these uncertainties, political representatives nevertheless have to make choices in terms of budget allocations between several priorities, but also on the basis of pressure from public opinion and from their hierarchy, who are often under pressure themselves, notably in terms of budgets. With a fixed budget or with very little room for manoeuvre, choosing whether to invest in diffe-
rent services – in prevention or in risk management measures – therefore implies giving up on other things. As part of a global prospective approach, taking “black swan” events into consideration is often of secondary importance. Faced with limited budgets, and urgent costs which are difficult to cover in essential sectors like health, education, access to housing, etc., taking into account low level risks is difficult, particularly as these are not generally covered by preparedness plans. In Haiti, the risk of earthquakes was not a priority despite appeals from a handful of Haitian specialists. We now know the consequences of this since 12 January 2010... Faced with future changes, probabilistic analysis of the past only informs us about future risks to a certain extent. And herein lies the difficulty of dealing with “black swans”. As we are unable to predict the future, only strategic and innovative reflection about extreme events, which is capable of going beyond statistical models, while pushing them to their limits, will make it possible to think about procedures for anticipating and managing them and provide solutions. Ignoring phenomena whose probability is very small is not a sign of wisdom because the ‘weak law of large numbers’ in probability implies that extremely rare events should be included in forecasts. This is one of the key pieces of advice from researchers and mathematicians who work on the theory of extreme events and how to predict them.7

One of the characteristics of extreme risks resides in the fact that an event can have numerous consequences which produce a series of “cascading” disasters.

As mentioned above, analysis of these exceptional events and preparation for their possible occurrence is prospective in essence. The work done by different bodies – including Groupe URD in a certain number of contexts (Indian Ocean, South and South-East Asia, and the Sahel), - is based on prospective multi-scenario analysis and tries to strengthen and delineate the anticipation approach based on knowledge of phenomena and events which have taken place in other parts of the world.

One of the areas of reflection is based on the modelling of telluric incidents which are examples of black swans. The history of the world and of humanitarian action is connected to global tectonism. From the Lisbon earthquake (1755) and the exchanges that it led to between Voltaire and Rousseau8, through the earthquake in Caracas in 1812, which led to the first large-scale humanitarian response by a State, and then those in Agadir (1960), in Managua (1968), in El Asnam (1981), in Armenia (1988), in Sumatra (2004), in Pakistan, in China (2005) and in Haiti (2010), human beings have continually examined deep tremors9 and the movement of tectonic plates to try to improve earthquake predictions, without too much success for the time being... Those who manage risk could begin to reason on the basis of possible causality rather than probabilities, remaining in the realm of uncertainty while looking to identify “risk factors” and useful investments: construction codes, urban development, measures such as “evacuation plans”, the reinforcement of “critical infrastructure” or other expensive things which have to be done if we do not want to have any regrets...

Given the size of the impacts of “black swans” on large populations, who are therefore more exposed, and on fragile economies, notably in delta and coastal regions, but also in the valleys of mountainous areas, they should be central to thinking about anticipation, prevention, prediction and preparation, in an increasingly large number of regions in the world. Thus, in Madagascar8 the meteorological services showed in 2008 that warming had begun in the southern part of the country in 1950 and had extended to the North from 1970 while there had been a great deal of variation in rainfall. Since 1994, the number of high-intensity cyclones has increased. Climate predictions for the next 50 years show that Madagascar will experience a general increase in temperature of between 1.1°C and 2.6°C. What is more, there will be a general increase in rainfall throughout the island, except in the extreme South-East. According to the same predictions, the frequency of cyclones will increase and it will be more common for them to cross the North of the island. The most recent cyclones which hit the Seychelles and the torrential rain on Mauritius can be categorized with other very rarely observed phenomena. Both in 2011 and in 2013, the cyclones which took place in the Philippines had unusual characteristics in terms of the period, the trajectory and the intensity.

Consequently, thinking about extreme and rare events which are very difficult to predict, such as tectonic risks, can shake things up. In certain areas, such as the Eastern part of the Indian Ocean, for example, seismic risk is often seen as a low level risk. However, the permanent tectonic activity throughout the region, an active volcano (Karthala and Piton de la Fournaise) and faults which are very active in Madagascar (tremors, thermal springs) mean that it is a high-risk area, particularly in certain parts of Reunion and the Comores. One of the characteristics of extreme risks resides in the fact that an event can have numerous consequences which produce a series of “cascading” disasters.11 There is more and more literature about “domino effects” and the importance of this risk is confirmed by the analysis in numerous evaluations and research by the scientific community. The following are examples of the consequences that these can have:

- The uncontrolled movement of people and goods, which is common in large-scale disaster contexts, due to the panic induced, but also the need to flee the devastated area. These evacuations, displacements and migrations of
affected populations from one country to another are not exempt from associated political and security risks. The detailed map of certain island areas (Indian Ocean and Pacific) shows that the population of certain islands will find shelter more quickly on an island of a neighbouring country than in the capital city of their own country, which creates a diplomatic problem. Similarly, a massive hurricane in Bangladesh which affects areas of the delta which are normally affected including the capital, Dhaka, could also lead to millions of people moving to “hostile” borders where the arrival en masse of people fleeing would immediately be seen as a threat. Military forces would then be deployed in considerable numbers;

- Massive pollution across the territorial waters of several States as well as international waters, with major contamination of densely inhabited coastal areas; or pollution of economically important areas for the management of fishing or tourism-related resources;

- The propagation of contagious, vector-based and/or infectious diseases linked to population movements and the deterioration of public health systems following a disaster. The recent Ebola, Cholera and Chikungunya crises are so many warning signals;

- Events which affect industrial installations and hydrocarbon and hazardous materials installations;

- Heavy rainfall which leads to landslides and mudslides which affect urban settlements.

As a consequence, the more we are faced with the unknown, the more important it is to think of the range of “sensors” and warning mechanisms, including early warnings and late warnings. As the former are unfortunately not very effective with regard to unpredictable phenomena, what will save lives is infrastructure and behaviour preparedness, successive levels of warning, and the discipline of the population when the alarm is sounded. These conditions need to be acquired based on innovative scenarios, “agile” operational mechanisms and reflexes which are gained from experience, for both specialist bodies (civil protection and security, Red Cross and Red Crescent networks, municipal staff) and the general public. Faced with black swans, we need to get out of our comfort zone, which is the knowledge of the past, and vigorously explore what is possible, uncertain and unpredictable.

François Grünwald
Executive Director, Groupe URD

1 See, for example, the work of Didier Sornette, about predicting disastrous events: http://www.ffsa.fr/webffsa/risques.nsf/h724c3eb326a8d4fc12572290050915b/0e7a2e743807747c12573ec0642e093/$FILE/Risques_50_0026.htm and that of Anis Borchani about the statistics of extreme values in relation to discrete laws: http://hal.archives-ouvertes.fr/docs/00/57/25/59/PDF/10009.pdf

2 IPCC website: http://www.ipcc.ch

3 Adapted from different sources on crisis management in businesses.

4 See: http://www.isse.ucar.edu/extremevalues/extreme.html


6 The governments of vulnerable countries are faced with important budgetary choices, which make the major investments needed for emergency preparedness (such as intensive training courses at the national, regional and local level) difficult. www.undp.org.mz/waterwind/defect/.../J1288


8 See the article “Changement climatique et cop17: enjeux et implications pour Madagascar” by WWF (22 September 2011). Available at the following address (in French): http://wwf.panda.org/fr/720479/Changement-climatique-et-cop17-enjeux-et-implications-pour-Madagascar

9 And their exchange about the relationship between events and societies which can lead to disasters.

10 See: http://volcansblogs-de-voyage.fr/2006/12/24/definition-du-tre

11 Un exemple d’effets de dominos: la panique dans les catastrophes urbaines: http://cybergeo.revues.org/2991

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13 Review n°14

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15 The terrible damage done by the Tsunami of December 2004


IMFREX website: http://mediast1.mediasfrance.org/imfrex/web/ Website which brings together statistics on extreme events: http://www.isse.ucar.edu/extremevalues/extreme.html

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The current situation facing Malian refugees in the Sahel: some operational ideas for a prolonged emergency situation

Valérie Léon

With renewed political instability in Mali since the end of May 2014 and humanitarian funding related to the Mali crisis on the decrease since 2013, it seems difficult to develop mid/long-term strategies for humanitarian response and resilience. Following three field visits to camps in Burkina Faso (Goudebo), Niger (Tillabéri and Intekane), and Mauritania (Mbera), the present article explores operational ideas to respond to the current challenges of prolonged exile for Malian refugees in the Sahel.

It is highly probable that a large number of Malian refugees are currently in neighbouring countries (Burkina Faso, Mauritania, and Niger) in areas which are remote, arid, under-developed and subject to recurring food crises (2005, 2010 and 2012). These Malian refugees belong to different ethnic groups: mainly Tuareg, Songhai and Arab, but also Hausa, Fula and Bambara.

During 2014, the number of returns has slowed and the recent events in Mali have led to more population displacement. Following the clashes between the Azawad National Liberation Movement (MNLA) and the Malian government (in the region of Kidal, May 2014), refugee leaders (notably those of the Mbera camp in Mauritania) expressed their reticence about going home, as they had been doing already for several months. The lack of desire to go home is due in great part to the current negotiation process and the lack of guarantees for a safe return (security and basic services).

In short, the humanitarian context in which the Malian refugees currently find themselves is characterized by:

- The complex and multi-factor nature of the crisis, involving food shortages and conflict.
- The decrease in funding for the Sahel.
- The non-resolution of the conflict and the lack of stable institutions in North Mali, which means there is a risk of extended exile for the Malian refugees.
- Recurring signs of imminent new food crises in certain areas of the Sahel.

As a result, humanitarian actors are faced with a number of issues which require different operational methods:

- The consolidation of the emergency phase and of the economic security of the refugees, with a view to their return or the prolonging of their exile;
- The strengthening of people’s resilience in a context of chronic food insecurity;
- The preparation of contingency plans in the case of a new influx of Malian refugees.
Facilitating returns and/or the local integration of refugees with the objective of finding sustainable solutions

In the future, returns will mostly be decided by fraction leaders (thus there is the possibility of “small group” or collective returns), and are therefore linked to the current negotiation process. The most politicized refugee leaders – many of whom went through a period of exile in the 1990s – insist that they cannot return to Mali as long as security conditions and minimal basic services (health, education) have not been re-established in North Mali.

Depending on how the context and needs evolve, the United Nations High Commissioner for Refugees (UNHCR) could consider facilitated return processes. When the circumstances were favourable (2nd half of 2013), UNHCR decided to facilitate spontaneous returns, in collaboration with HCR Mali, who are responsible for the follow-up in terms of protection and reintegration programmes (such as the distribution of supplies).

This said, there is a risk that the implementation of such a programme would come up against several concrete difficulties. Due to limited presence in the field and the prevalence of areas where there is insecurity, the HCR will find it difficult to provide the returnees with protection, even if this was just in forming them of the situation in the regions they are returning to (safety, rehabilitation and functioning of basic services...). It will also be particularly difficult to monitor returnees and to avoid the possibility of to-ing and fro-ing between return areas and host areas whereas the security situation could deteriorate suddenly in certain localized pockets.

According to the recent report by the African Union and despite the ceasefire agreement which was signed on 23 May, the situation remains marked by persistent security incidents and the pursuit of attacks by the armed terrorist groups who are still active in the three regions in the North (Gao, Kidal and Timbuktu), such as in the Adrar des Ifoghas, in the extreme north-east of the country. Numerous attacks, kidnapping incidents and clashes between communities have also been reported in recent months.

The report by the African Union’s Peace and Security Council also states that the “continuous deterioration of the political and security situation in Libya, compounds the security concerns in the region”. At the same time, the countries in the region are pursuing their efforts to reinforce security cooperation and put into operation the African Peace and Security Architecture (APSA) in the Sahelo-Saharan region (Nouakchott process launched by the African Union in March 2013).

Preserving peaceful cohabitation, by generating development gains for the host communities

In general, cohabitation with the local population is deemed to be “excellent” by the refugee leaders, notably as it is based on socio-cultural and even family ties.

Around the refugee hosting areas in Niger, the local population have access to free healthcare in the health centres supported by UNHCR within the host areas. This has made peaceful cohabitation possible when refugees have been relocated (from areas over the Malian border), as have other development-type projects such as the rehabilitation of a drilling site, or a dam, or the setting up of a water conveyance system. Indeed, it seems that a certain number of nomadic families in the region have “settled” in the village near the refugee hosting area.

However, in certain contexts, the chronic vulnerability of local communities could soon reveal problems in terms of aid equality and generate protests, like those that took place in the Mbera camp in Mauritania in 2012 and 2013 during the registration and the removal of a large number of people from the assistance register (which were also due to changes in the distribution method).

To avoid such incidents, parallel efforts should be made to contribute to the recovery and resilience of the local communities who suffered from the last food crisis in 2012 and remain chronically insecure. Indeed, another food crisis cannot be completely excluded given the low level of improvement of malnutrition indicators in certain geographic areas.

In hosting areas, the presence of refugees and their herds, which are sometimes very big, as well as a certain “fixing” of the local population, combine to create additional pressure on natural resources (water, pasture, etc.) which may cause tension in the medium term.

Operational issues therefore include the supply of water, the use of pastureland and waste management, both for refugees and the local population. This is why several activities have been carried out in and around the camps, such as: the rehabilitation and construction of drilling sites, the establishment and/or reinforcement of water management committees, awareness-raising campaigns about hygiene and public health, etc.

Around the Mbera camp (Mauritania) for example, pressure on water resources is particularly high in areas (more than 20 km from the camp) where there are some pastoral wells and where there is a concentration of Mauritanian

It will be particularly difficult to monitor returnees and to avoid the possibility of to-ing and fro-ing between return areas and host areas whereas the security situation could deteriorate suddenly in certain localized pockets.
and Malian herds which are estimated to be 35,000 and 180,000 (!) strong respectively. In the future, aid programmes will have to aim for integrated and strategic management of environmental resources (water and pasture), based on more detailed knowledge of pasturage and water tables, such as where they are located and how they are regenerated, land ownership rights and the social management systems that are associated with them.

At the national level, and in consultation with United Nations agencies and the political authorities, the HCR contributes to drawing up action plans which will facilitate the transition to mid- to long-term solutions, with the objective of conflict prevention and peaceful cohabitation between refugees, returnees and host communities (who are often herders, like the majority of Malian Tuaregs). To support the mobilization of funds by the host country, the HCR is involved in a regional initiative called Conflict Prevention and Peaceful Cohabitation which was presented in Nouakchott in April 2014. With a view to return processes of this kind (spontaneous and initially facilitated), the HCR and its partners underline the importance of the needs of host populations who have taken in the refugees and immediately shared their meagre resources, and who continue to face the difficult living conditions in this region of the Sahel (water, food security, health and education).

The HCR is certainly at a pivotal moment when the emergency response needs to open the door to mid- to long-term actions in order to build resilience. This transition movement will have to take place in close collaboration with the government, the regional authorities, the local technical services and development organizations.

In addition, as part of the United Nations’ integrated strategy for the Sahel (2014-2016) and the Strategic Response Plan, the HCR is very active within the Resilience group in order to ensure that the refugees will benefit from these programmes. The UNDAF process of reflection and strategic planning also provides governments affected by the Malian refugee crisis with support.

Sowing the seeds of tomorrow’s resilience: education, economic security and changes in behaviour

In these chronically vulnerable host regions of the Sahel, it is of primary importance to design and coordinate socio-economic support programmes, both for refugees who are preparing to go home and also for host communities and those who have been reintegrated. In order to do this, a variety of joint evaluation missions have been put in place during 2014 in order to identify potential and priority operational sectors (in Niger and in Mauritania). Consequently, if we look at the situation in terms of community resilience and self-sufficiency, the presence of refugees can be seen as a factor of development on which organisations can base their operational strategies. According to the Joint Assessment Mission (JAM) carried out in Niger, their presence has boosted the markets around the Intekane refugee hosting area and considerably developed the area, thanks to the increased availability of water and healthcare, and also due to the increased trade made possible by Tuareg networks between Mali and Niger. According to the prefect, “a city has been born”. In the same way, the influx of humanitarian aid has stimulated the markets and the region of Bassikounou at a time when the Mbera camp was considered to be the third biggest city in Mauritania.

Of course, these phenomena may turn out to be transitory depending on the possibility of returns (whether long-term or not) and the splitting up of Tuareg fractions who sometimes define themselves on the basis of local markets which emerge.

- Food and economic security

Assistance programmes should be combined with support for the refugees’ productive capacities in order to help them become self-sufficient.

There is already a great deal of demand on the part of the refugees for educational programmes, literacy programmes, professional training and programmes promoting individual and community income-generating activities (IGA). IGAs would make it possible to include the refugees more in the return process, to make aid investment more sustainable and eventually promote the economic and financial autonomy of returnees in Mali.

Supporting the self-sufficiency of refugees would make it possible to develop un-exploited economic potential, such as cross-border trade, which is a characteristic and “comparative advantage” of these nomadic communities (refugees and hosts).

Another interesting course of action which could benefit both host and refugee communities would be livestock support programmes, with or without slaughter. Buying animals from a few herders helps to distribute live animals (for the rearing of small ruminants) or food to certain beneficiaries. At the same time it injects money and stimulates the local economy.

When there is a drought in the future, destocking operations will help to control the size of the herds by limiting the risks of famine and disease for the remaining animals. This type of activity can be organized in collaboration with the local veterinary services (setting up of slaughtering areas) and with women’s cooperatives for the preparation of dried meat. ICRC’s activities in this area in Mali and Niger have been edifying.
By giving disadvantaged people means of production and a social activity, IGAs also have positive effects in terms of protection and gender equality. Productive activities reduce the adoption of harmful coping strategies (e.g. difficult activities for women and children in mining sites and/or prostitution). They also encourage social interaction, expression and involvement in decision-making within households and the community.

Education

In the Education sector in the camps, the HCR’s results fall short of their objectives. In April 2014, school attendance rates were estimated to be around 50% in Tabareybarey camp in Niger, 38% in Mbera camp in Mauritania (though only 15% for 12-17 year olds) and 25% in the Godebo camp of Burkina Faso.

This is explained by the fact that the targeted population, whether refugees or local, are not very familiar with school. As a consequence, educational capacity is generally very weak in the areas where Malian refugees are taken in. To provide education in the camps, everything had to be built from scratch: the building of the schools, recruitment, teacher training, and raising awareness amongst the parents about the importance of education and regular attendance at school. Though this action strategy can meet the needs of communities in exile in part, it is nevertheless not adapted to pastoral communities who are nomadic. Ideally, mobile education systems should be developed and put in place.

Within refugee communities, the activities of the HCR and its operational partners should be supported to promote the schooling of girls and children from disadvantaged groups (particularly the Bellas and mixed families) and to keep children at school. Currently the possibilities of reinsertion are not sufficient for children (10-11 years old) who have never been to school, for example, via literacy programmes and professional training. This age group requires specific attention as they can become the target of forced recruitment.

According to a variety of interlocutors, food assistance is crucial to attract and retain people who for the most part have never been to school and do not see the point despite the awareness-raising sessions.

The involvement of the national authorities is sometimes exemplary, as in Burkina Faso where the Ministry for Education (MENA) appointed 22 tenured teachers who are responsible for teacher training and pedagogical follow-up. These efforts are all the more commendable in that there is a shortage of teachers (407) for the Sahel region. Finally, advocacy by HCR has proven to be fruitful, with the construction of a large school in Goudebo which will be used by host villages in the future, and support provided to state schools in the region.

Awareness-raising and behaviour change

Certain social barriers are said to limit access to and the impact of the community services supplied (health and education in particular).

Though resistance remains strong, humanitarian operators have nevertheless observed a certain breakthrough since 2013 as sensitive subjects can be discussed in women’s groups and young people’s groups (such as discrimination, early marriage and its consequences, and a few cases of gender-based sexual violence, such as rape and sexual exploitation). The most sensitive subjects are dealt with in small restricted groups (FGM, sharing of aid by low castes, exploitation and forced recruitment of children, etc.) or during the provision of services (such as in health centres).

These themes are also relevant for host populations as their ways of living and customs are very similar to those of the majority of Malian refugees (Tuaregs).

Experience shows that many subjects can be treated due to regular presence and culturally appropriate communication. To improve the detection and follow up of cases, it is of primary importance to establish communication between various focal points, whether they are linked to a partner organisation (for example, a community relay or worker), the HCR (pre-interview during the recording) or at the health post. As such, the cultural proximity of the staff working with the community is a priceless asset.

Certain culturally-adapted messages can lead to isolated cases of behaviour change which then spread within the community. Humanitarian operators recently pointed out the following situations: fathers deciding to send their girls to school rather than marrying them; preference expressed by members of inferior castes for local reintegration in order to escape the hierarchical system. A Tuareg leader also revealed that many returned parents regretted not having sent their children to school at the camp because when they returned to Mali they understood that it would have helped them find work.
Conclusion

The communities of Northern Mali have been displaced many times and even though exodus is always an ordeal, being pastoral and nomadic gives these communities a key asset in the face of the vagaries of climate. However, political instability, the fear of violence and the non-recognition of their demands mean that it is currently difficult for them to return.

The vast majority of Malian refugees will only return on the condition that the conflict is resolved, and law and order and basic services are restored. But the political instability in Mali and the difficulties in providing a minimal guarantee of a safe return in the long term mean that prolonged exile is likely, and even local integration of the refugees in Sahelian regions which are chronically vulnerable and still affected by a food crisis.

With the possibility of new arrivals, the main operational challenge today is to link emergency solutions and medium-term support (for refugees, for those who have been reintegrated and for local communities). This means that the usual distinctions need to be avoided (between categories of people, between emergency and resilience solutions, etc.) and there needs to be greater coordination between humanitarian and development actors (sharing of contextual and vulnerability analysis, and making programmes complementary). This is the case for the REGIS initiative (funded by USAID), which is being launched in Niger and Burkina Faso, and which will provide support to communities affected by the Malian refugee crisis.

Finally, the mobilisation of resources by donors should be more systematically adapted to expected changes in the context and should be based on prevention rather than crisis management. The ability to adapt programmes to changes in the context remains an area where there is a great deal of room for improvement.

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1 The latest individual records gave the following distribution in Niger (February 2014): 79% (Tuaregs), 12% (Songhais), 2% (Arabs) and in Burkina Faso (June 2014): 77% (Tuaregs), 11% (Arabs), 2% (Songhais). In July 2013, in Mauritania, the majority of refugees were Arabs (54%) and Tuaregs (45%).
2 http://unicefmauritania.org/monthly-situationreport-november-2013/
4 As opposed to a « drip-by-drip » individual return process.
5 For example, by giving around 70 USD for transportation.
6 The World Bank could also provide support.
7 Groupe URD organised a round table on issues of humanitarian space in Bamako in February 2014. http://www.urd.org/Workshop-Humanitarian-space-and-
8 The terms of the agreement are that the armed groups who were occupying the town of Kidal (such as the MNLA, the Haut Conseil pour l’unité de l’Azawad - HCUA, le Mouvement Arabe de l’Azawad - MAA) made a commitment to end hostilities, to take part in inclusive talks, to free the members of the Malian security forces and the civilians that they had taken as prisoners and to facilitate humanitarian operations. As for the inclusive peace talks launched in Alger, they allowed a Declaration of the end of hostilities to be adopted (24 July 2014) at the same time as the Peace process Road Map, thus strengthening the ceasefire agreement.
9 Among the activities carried out successfully were crafts (leatherwork, jewellery-making), livestock rearing and recycling of plastic bags.
10 Out of a total of 100 million USD, support for returns and socio-economic integration (local re-integration) represents 25 million USD. Currently, the rate at which the strategic response plan is being funded is 3%.
11 Several working groups and initiatives at the sub-regional level include representatives of governmental institutions, United Nations agencies, NGOs, donors and other stakeholders. They constitute forums for the exchange of information, situational analysis and coordination of crisis preparedness and response. In addition to the theme of Resilience, there are also working groups on food security and nutrition, emergency preparedness and relief, disaster risk reduction and the Mali crisis (Mal+).
13 JAM: Joint Assessment Mission PAM/HCR, September 2013.
14 Out of a total of 100 million USD, support for returns and socio-economic integration (local re-integration) represents 25 million USD. Currently, the rate at which the strategic response plan is being funded is 3%.
15 Current Tuareg society is always based on a rigid socio-political hierarchy which includes several categories: nobles (inzajeghen), tributaires (imghad), religious (ineslemen), serfs or former serfs (iklan or Bella depending on the Songhay terminology).
16 The term of a mixed family refers to cases where children have been given to another family, generally from a superior caste, to work for them.
17 MENA : Ministère de l’Education Nationale.
18 These indicators were supposed to be clarified thanks to the registration operation being carried out at the time of the field visit. These rates may have been pushed down due to over-registration.
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21 The term of a mixed family refers to cases where children have been given to another family, generally from a superior caste, to work for them.
22 48 classrooms have been built for refugees, whether in the camp of Goudebou or « outside camps ». In addition, around ten classrooms have been built to support public schools in the region.
23 The term of a mixed family refers to cases where children have been given to another family, generally from a superior caste, to work for them.
24 FGM: Female Genital Mutilation. These are still not broached easily. In Mbera camp in Mauritania, in some limited circles, discussion apparently can take place.
25 Goudebou camp in Burkina Faso.
Epidemics and pandemics: thoughts on health risks

Major pandemics are not a new phenomenon. Some of them form part of the collective memory of humanity such as the plague, cholera and Spanish influenza, which ravaged certain regions of the world including Europe at various times in the past. The history of these major epidemics is closely linked to the increase in mobility of goods and people: diseases transported by explorers and traders (tuberculosis, syphilis, measles, etc.) had a devastating effect on native populations. The demographic impact of these epidemics on entire regions like Latin America and the Caribbean has shaped history with the disappearance of the “original inhabitants”.

Box 1. The plague in Europe

During the Middle Ages, the plague, which had spread throughout Europe, disappeared both in the West and in the East. In 1346, having disappeared for six centuries, it reappeared in the region of the Black Sea. The battle between the Mongols and the Genovese in Constantinople led to the contamination of communities who fled, thus spreading Yersinia pestis to Messina, then Marseille via the galleys which landed there in November 1347. The plague reached Paris in June 1348, then England and Flanders. From the Muslim world to Western Europe, the plague decimated populations and weakened social structures. In a few months, the plague wiped out between one third and a half of the population of Europe. It is difficult to make a more precise estimation. We can only get an idea of the scale of the disaster from registers of baptisms and burials. But all calculations reach a figure of at least 40% of deaths in each village. The economic consequences of the plague were also huge. Lack of labour led to the disruption of production. Fields remained uncultivated and entire villages were abandoned. It was not until the second half of the 15th century that the impact of the epidemic was partially repaired.

Old infectious agents which present new risks

Though old, the influenza virus remains a potentially significant source of mortality. The Spanish influenza virus, which hit Europe immediately after the First World War, was much more deadly than the conflict itself.

Box 2. The major Spanish influenza pandemic 1918-1919

Immediately after the First World War, Europe and the rest of the world experienced a new devastating epidemic. Between February 1918 and April 1919, the so-called “Spanish” influenza pandemic affected half of the world’s population and killed between twenty and forty million people. It is estimated that 165 000 people died of it in France. The influenza pandemic of the winter of 1918-1919 is an early example of the propagation of a pandemic and a source of important lessons due to the new dangers which have begun to appear. In the Spring of 1918 an initial wave of influenza, which was contagious but not virulent, preceded the deadly pandemic of the Autumn. The disease appeared simultaneously in North America, Europe and Asia. In the United States, it particularly affected soldiers in garrisons. In Europe, there is no indication that the first cases were in Spain. All that is known is that it was identified early in Spain. Today some suggest that the disease first appeared in the United States, then spread quickly to the rest of the world due to the movement of troops. This theory would explain why the first cases in France were in the Bordeaux region, where ships from across the Atlantic landed. In October 1918, doctors noticed that the second wave of influenza had a number of specific characteristics. The number of cases was high, particularly amongst young patients who had not been immunized by the pandemic of 1890 and amongst women. Also, the clinical picture was very serious, including clear general signs, constant respiratory complications, followed by frequent and serious pleural, digestive and cardio-vascular complications. After an initial moderate flu syndrome which rapidly improved, many patients resumed their normal activity due to the difficult economic and social conditions. They were then taken by surprise by the brutality of the relapse: the symptoms were a high fever, marked tiredness, shortness of breath and exhausting cough. Many patients who were too tired or too busy to go to hospital were suffering from acute respiratory distress syndrome, and even cardiovascular collapse, when they eventually went for a consultation. The means available for diagnoses at the time were modest. Questioning remained an important part of the process to identify if they had been directly contaminated by a friend or relation or indirectly having...
The lessons learned from this episode are still sadly relevant today: the importance of controlling movements, the role of providing people with information, the need to combat stereotypes, to take into account major constraints and to manage the significant economic consequences.

One of the difficulties is that these viruses regularly modify themselves. Certain changes are due to human activity, and notably activities which lead to the mixing of human and animal populations. For example, intensive poultry and livestock farming have favoured hybrids and the emergence of new viruses. These can be relatively benign, even if they are very contagious (swine flu H1N1) or less contagious but very dangerous (avian flu H5N1, SARS) (cf. Map below).

Breeding grounds and the propagation of H1N1 and SARS

Resistance to known treatment is of increasing concern. This is caused by the development of self-medication systems, the increased and uncontrolled use of antibiotics and the presence of medicinal products of questionable quality on the markets of numerous countries in the global South. Thus, *streptococcus pneumonia* and the tuberculosis bacillus (Koch bacillus), which were very sensitive to antibiotics fifty years ago, have developed a worrying level of resistance to them in recent decades: people are now being killed by simple streptococcus bacteria. Not only are viruses more and more resistant, but human beings’ immune systems are becoming more and more fragile because they do not come into contact with these viruses regularly.

A study published in the August 2010 issue of The Lancet sounded the alarm following the appearance and rapid spreading of multi-resistant bacteria via medical tourism patients to South Asia and these are also present in Europe, the United States and Canada.

Box 3. The arrival of new multi-resistant pathogenic agents

Bacteria are more and more resistant to conventional antibiotics. 10 years ago, the main concern was Gram+ bacteria such as *staphylococcus aureus* which are resistant to meticillin, and *enterococci* which are resistant to vancomycin. It is now being recognized that the multi-resistance of Gram– bacteria also poses a major risk to public health. Not only does resistance spread much more rapidly with Gram– bacteria than with Gram+, but there are also far fewer new antibiotics available or being developed for this range of bacteria. The increased resistance of Gram– bacteria is linked to the high level of mobility of genes which can be disseminated by the plasmids in the bacterial population. The increased mobility of human beings via air travel and migration means that bacteria and plasmids are rapidly transported from one country or continent to another. This dissemination cannot be detected as the resistant clones travel within human bacterial flora and only become apparent when they are a source of infection. The appearance of Gram– *enterobacteriaceae*, transferred by the New Delhi *metalla-beta-lactamase* (NDM-1) gene, which is resistant to the majority of antibiotics, is a major global health problem.

Sources of epidemics and propagation of the H1N1 and SARS viruses
The decision to raise the alarm should also be based on the highest ethical standards. The case of the H1N1 virus (cf. box 4) raises questions about the problem of States or international institutions not having their own experts who are independent of lobbies. Furthermore, if the alarm is raised frequently in situations which turn out to be unjustified, there is a risk that the whole early warning and rapid reaction system will lose credibility. There are very few antiviral medicines; therefore preserving their effectiveness should be a priority. It is regrettable that the French Ministry of Health issued injunctions to doctors to treat all cases of the flu with the antiviral drug Tamiflu during the winter of 2009 when there was a risk of an H1N1 epidemic. Apart from the fact that its effectiveness is scientifically questionable, it is certain that its overuse will ensure that the product becomes ineffective due to the resistance this creates.

Contemporary epidemiological dynamics

With social changes and the probability of mutations transforming harmless biological entities into potentially very effective vectors of mortality, humanity remains confronted with new sanitary risks.

The AIDS virus (HIV)

HIV is an example of a “new” atypical virus. It is contagious exclusively via sexual activity and blood contamination; it targets specific population groups on the basis of behaviour, develops slowly and moves almost inexorably towards death, predominantly amongst the young. This virus revealed particular weaknesses in the societies of the North and the South. To this, one must add the incompetence and inappropriateness of health systems as well as their lack of means. The violent rejection of victims by society and the resulting exclusion disrupts the whole of society in certain African countries where almost one in two young adults dies of or has the disease. This has major repercussions socially, economically and in terms of security:

- Entire areas of Malawi and Zimbabwe are no longer self-sufficient and cannot provide cities in the region with agricultural produce because there is a shortage of workers;
- Feeling that they have no future, AIDS victims adopt desperate behaviour which ranges from pillaging to sexual assaults.

Though things have evolved after 30 years of intensive awareness-raising campaigns, the development of new treatments (triple therapy, etc.) and changes in relation to at-risk behaviour and the social lives of infected people, we are regularly reminded about the fragile nature of this progress. As soon as an improvement is identified, at-risk behaviour immediately re-appears. For a long time, the cost of treatment excluded whole sections of the planet from basic access to triple therapy. Thanks to organizations like MSF who have invested a great deal in advocacy, substantial progress has been achieved in terms of access to treatment. This must now be established in the long term...

Box 4. The difficulty of managing the new pandemics

In June 2009 the WHO announced that there was a pandemic of the H1N1 virus. The President of the Council of Europe’s Health Commission, Wolfgang Wodarg, a German doctor and epidemiologist, asked for an investigation to be carried out into the role of pharmaceutical firms in the way the influenza A virus was managed by the WHO and individual States: “We are faced with a failure of the great national institutions charged with alerting us to the risks and responding to them should a pandemic arise. In April, when the first alarm came from Mexico, I was very surprised by the figures the World Health Organization was advancing to justify the proclamation of a pandemic. I had suspicions immediately: the figures were quite weak and the level of alarm very elevated. There weren’t even a thousand sick people before there was already talk of the pandemic of the century. (...) In reality, nothing justified sounding the alarm at that level. That was only possible because the WHO changed its definition of pandemic at the beginning of May. Before that date, it was not only necessary that the illness break out in several countries at once, but also that it have very serious consequences, with a number of mortalities in excess of the usual averages. That aspect was erased from the new definition, while the only criterion retained was that of the rate of the illness’s diffusion...” Experts linked to pharmaceutical firms are suspected to have had a major influence on decisions at the level of the WHO and national governments. A considerable amount of alarmist information was then sent out and vaccination campaigns began at considerable and no doubt disproportionate cost for health systems: around 700 million Euros in Germany, almost 800 million in France... All this to contain an influenza epidemic which by January 2010 had “only” claimed the lives of 300 people, compared to between 5000 and 10 000 people who die from “normal” seasonal influenza.

(Source: http://grippe-a-h1n1.over-blog.com)
Other very dangerous pathogens, such as those of the hemorrhagic fever viruses, like Ebola and Marburg, known as class P4 viruses, were for a long time associated with a high level of local mortality but it was rare, till recently, that they developed into major epidemics. They were affected by the “clearing syndrome”, breaking out in isolated villages in the equatorial forest so that the infected area remained of limited size. The epidemic would end quickly due to the speed with which the virus killed, thus preventing the infection from spreading. The population would fall below a certain level thus preventing the virus from being transmitted and reproduced. This, however, did not mean that the virus did not survive, and new hosts have recently been discovered amongst the fauna who can transmit the virus directly to humans (bats). The phenomenon can therefore be reactivated. The current Ebola epidemic shows that in a world where mobility is one of the keys of the economy at all levels (moving to cities to find work, trade in agricultural produce, tourism, etc.), which has been made easier by improving means of transport, and where fear leads to people fleeing an area, the classic model of the end of an epidemic no longer works. The virus, which previously remained confined in a forest, quickly spreads to cities and crosses borders.

The international community is waking up to the fact that considerable efforts will be needed to help West Africa to contain the propagation of the Ebola virus, to deal with the humanitarian and economic consequences of the crisis, and to improve public health systems. The realization that the epidemic could easily cross not only borders, but continents, and become a real problem outside its traditional forested areas of Africa, was a major catalyst for these international efforts. Is this “too little, too late”, as MSF has complained?

The SARS epidemic broke out in countries which, in the end, were capable of dealing with it, having significant financial resources and relatively competent and well-equipped health services, as well as politically strong governments. The Ebola epidemic, on the other hand, began in poor countries, with health systems in decline and governance systems still in construction after years of crisis and conflict. It also began at a time when the World Health Organisation (WHO) is in a depressing financial state, with cuts of several hundred million Euros and a major reduction in its early deployment capacity. The WHO’s budget is now 3.98 billion US$, while the Atlanta Center for Disease Control (CDC) has a budget of around 6 billion. There may be a terrible price to pay for this situation, but there is also probably a great deal of imagination being applied in different public and private laboratories... Those who find a solution will be in the running for a Nobel prize...

The World Bank Independent Evaluation Group identified the following 10 key lessons to enhance the development effectiveness of project support from the international community in response to the Ebola epidemic (IEG-WB)

1. Weaknesses in health systems are a major contributing factor to disease risk, especially from the lack of trained and equipped medical personnel, contract tracing capacity, sample collection and transport capacity, laboratory diagnostic capacity, and intensive care units with isolation capacity. The crisis response should support not only immediate emergency interventions but also medium-term risk reduction through public health system strengthening, recognizing that future opportunities to engage may be limited once the crisis has passed.

2. Capacity building efforts should be done in a way that are relevant to more than just a single disease, and should consider from the outset means to build sustainable systems that last beyond the current emergency. This would likely include support for animal health and veterinary systems, in addition to public health systems, and for managing other zoonoses and infectious diseases.

3. Develop a strong and effective partnership platform to coordinate the diverse support from different international actors, within the WHO-led strategic framework approved last month. Partners should focus on their specific areas of comparative advantage – for the World Bank Group, this would include building public health system capacity.

4. Complement national level investments with regional approaches for cross-boundary collaboration on regional public health goods, particularly in the areas of surveillance and monitoring. However, efforts to try to prevent disease transmission through border control may be ineffective, especially in countries with weak border control services and porous land borders.

5. Communication and awareness campaigns and outreach play an important role in responding to disease outbreaks, especially in areas where the population may have little information about the disease, its transmission mechanism and safe behaviors, and where people may be sceptical of medical interventions. Communication training for key public officials can be useful, as can efforts to engage with the news media to reduce misinformation and overly alarmist messages.

6. Hit the right balance between responding quickly and conducting the necessary technical analysis and project preparation to ensure effective design of interventions. Postponing important technical design work until after project appraisal can lead to costly delays to the start-up of project activities and the procurement of critical goods and services.

7. Balance investments in physical infrastructure, such as laboratories and equipment, with institutional develop-
The emergence of infections, and previously unknown ways of being infected

As understanding of this domain has improved, new dangers have been identified. Prions are a new form of infectious and contagious agent (neither a bacteria, virus, fungus or parasite, they are composed primarily of protein), against which little can currently be done. “Mad cow disease” is an example. Probably caused by an inappropriate method of feeding animals, it provoked a massive health and commercial crisis. The economic and social impact of this type of epidemic is still contained for the time being as the areas affected were located in countries with the legal, regulatory and logistical means to face up to and control the phenomenon. Looking ahead, there is no reason why new pathogenic agents of varying contagiousness, rapidity and dangerousness will not appear from time to time in either the animal, human or inter-species domains.

Public health issues in congested environments: when a crisis creates a public health time bomb

The increased urbanisation of recent decades has revealed new dangers. Health conditions in slums, in a city affected by war or a disaster, represent a major threat due to the combined challenges of the size and density of a population, which are the two key variables in a “contamination equation”. This, of course, is made worse in contexts where there are a large number of IDP camps of all shapes and sizes, in densely populated areas where the people are poor. Examples include Mogadishu, Manila and Port-au-Prince. These cities hold numerous risks for public health, and the potential impact is very high due to overpopulation, the poor (or very poor) sanitation and the mediocre nature of the majority of shelters. Tuberculosis is often spread due to the way displaced people’s shelters are designed, particularly when they are built in overpopulated areas. Diarrhoea is a frequent problem and there is a high risk of cholera epidemics, which is directly linked to the deplorable health conditions in which numerous displaced people live. Malaria is also a recurring problem, with a great deal of seasonal and geographic variations. Measles is also one of the most common causes of infant mortality in cities. In numerous classic humanitarian operations, displaced people in camps are often the main beneficiaries of public health programmes provided by aid agencies. However, when healthcare is provided to the displaced people, it is often necessary to extend it to the surrounding population. Indeed; the large number of health centres in camps where the neighbouring urban population do not have access to healthcare is unfair and is a source of both health and security problems.

It is necessary to address this issue in a more strategic manner with the development of an urban health card, a spatial strategy to responding to the health needs of communities and the displaced persons in the nearby urban camps.

In addition to the epidemiological risks related to population density (risks of rapid and large scale contamination, and the propagation of acute respiratory diseases), and inappropriate hygiene and sanitation conditions (waterborne diseases, cholera, etc.), urban contexts cause other kinds of public health problems.

Vectorial transmission diseases are a very complex health problem which requires a specific approach in urban contexts following a disaster (OPS, 1982). Eliminating vectors or maintaining them below a certain threshold requires a vigorous public campaign and the political commitment of the municipal authorities.

Conclusion: Health problems and security issues

Sanitary risks have a number of common characteristics: newness, external origin (how it develops), potentially high impact, disruptive to society and its values and a socio-economic impact which creates the need for more regulation. Sanitary risks are related to three types of insecurity:

- Biological insecurity, linked to the risk of transmittable infections. This is the type of insecurity which is recorded...
most frequently and it is becoming an increasingly globalised phenomenon. It brings the possibility of exclusion and confrontation between healthy and sick individuals and between countries which have been affected and those which have not. This is all the more true as demand for antibiotic and retroviral treatment and the supply of uncontrolled medicine grow. Anticipation of this growing risk is extremely important (cf. H1N1 flu).

- **Food insecurity**, in the sanitary sense (safety). Situations where there is food insecurity such as the “Mad Cow” crisis, and their major economic repercussions (with destabilization of markets, protectionism, embargoes, etc.), could be a significant source of vulnerability in relation to supply and commerce. Another form of insecurity could be the battle over Genetically Modified Organisms (GMOs), which has similarities to a biological war. GMO products used in agricultural production can have a significant effect in terms of genetic pollution if wild species of the same plant exist in the ecosystem (the case of GMO colza and the numerous self-propagating plants from the Cruciferae family present in the area where it is cultivated). Transmission by pollinating insects and linked to proto-viral (prion) forms of genome transfer, whose fundamental importance we are gradually coming to learn, are making the dissemination of modified characteristics similar to contamination.

- **Environmental insecurity**, the vaguest of the three. The environment is increasingly at the source of certain pathologies, such as those produced by problems linked to the stabilization of markets, protectionism, embargoes, etc., could be a significant source of vulnerability in relation to supply and commerce. Another form of insecurity could be the battle over Genetically Modified Organisms (GMOs), which has similarities to a biological war. GMO products used in agricultural production can have a significant effect in terms of genetic pollution if wild species of the same plant exist in the ecosystem (the case of GMO colza and the numerous self-propagating plants from the Cruciferae family present in the area where it is cultivated). Transmission by pollinating insects and linked to proto-viral (prion) forms of genome transfer, whose fundamental importance we are gradually coming to learn, are making the dissemination of modified characteristics similar to contamination.

Faced with these different global risks, the response is still often national or even local (for urbanism and transport) and can vary from one country to the next. There are often problems in establishing a response at the regional level, whereas epidemics often rapidly cross borders. The risk of conflict within a country or between countries significantly hinders the implementation of appropriate responses. Certain authors have been arguing for the implementation of surveillance systems which are adapted to high risk contexts for more than three decades (OPS, 1982). They claim that these systems are essential for anticipation and rapid reaction, two fundamental components of the management of acute health crises. This poses a major problem in terms of developing international health strategies to meet the challenges that humanity will face in the coming decades. The inter-continental transmission of cholera to Haiti has meant that the island has gone from being “free of cholera” to being “cholera endemic” and the whole of the Caribbean is potentially affected. The current Ebola epidemic in West Africa and its international ramifications led the WHO to declare a public health state of emergency and to launch an international mobilization, the first of its kind. It will be necessary to learn lessons from these cases.

To conclude, the links between health security and public security are numerous and take many forms. Disagreements about causes and responsibilities are also frequent, with competing reactions and responses which are related to social issues and international relations. The difficulties that managers and international institutions have encountered, due to a lack of vision and anticipation, with people reacting in panic and attacking medical staff, and the human, economic, social, and even societal damage that results, mean that these health crises are a major issue which we will need to tackle rapidly before it is too late. And we will all have our role to play!

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1 This article follows on from an initial publication on “Hots spots” ([http://www.urd.org/IMG/pdf/HS04.pdf](http://www.urd.org/IMG/pdf/HS04.pdf)) and various evaluations in Haiti which include the response to the outbreak of cholera. It includes elements from a multi-disciplinary research project on future non-intentional risks which was carried out in 2010.


4 In order to treat these viruses (Ebola, Marburg, Lassa, Congo) some very protected laboratories have been created which are known as P4 laboratories. Authorization is needed to enter one of these laboratories. The entry procedure is very restrictive to avoid contaminated materials from coming out. One has to shower, wear a pressurized protective suit (positive pressure so that if the suit is accidentally torn, air comes out rather than going in, thus avoiding all contamination), which is connected to a source of air from outside the laboratory. When leaving the laboratory, a chemical shower while wearing the suit is obligatory before going out.

5 This term was first used in 1982. The first description of Creutzfeldt-Jakob disease dates back to 1920.
Introduction

Many organisations who are active in the WASH sector in humanitarian and development contexts are currently questioning the effectiveness of the assistance provided, with respect to the objective of reducing water-borne diseases. WASH operations are often designed and evaluated in quantitative terms (e.g. number of water points and latrines installed). These results mask a very different reality in the field where many installations are seldom used or used improperly and are often not sustainable. The impact of WASH operations on the reduction of water-borne diseases is not very well known and there are probably many examples of operations which have worsened pre-existing situations.

Installing or repairing infrastructure may not have the expected effects if the geographic, cultural and social realities of the targeted communities are not correctly taken into account. Indeed, though the installation of infrastructure should make the environment more conducive to appropriate WASH behaviours, it does not guarantee changes in behaviour in itself. This is where raising awareness about hygiene comes in, which is now recognized as a major part of WASH operations. However, awareness-raising activities are rarely integrated into operational strategies which focus primarily on technical choices and the installation of infrastructure. In addition, one-size-fits-all methodologies are repeated without taking the trouble to contextualize them. What is more, the great majority of awareness-raising activities are based on health messages focused on the dangers of “bad” behaviours rather than on the expected benefits of appropriate behaviours; it is assumed that once the population has been warned of the risk of contamination and the danger of water-borne diseases, they will adopt the thousand and one practices that are encouraged during these awareness-raising sessions. Here again, field realities are very different. The “good” practices which are promoted are restrictive and sometimes imply a major change in family habits. What is more, family habits are subject to a whole range of constraints and influences which are specific to their environment. This can sometimes facilitate changes in behaviour, but more often acts as a barrier to change.

The A.B.C.D. approach was developed in the light of the limits mentioned above. It is based on the work of the London School of Hygiene and Tropical Medicine and the Swiss Federal Institute of Aquatic Science and Technology as well as the socio-anthropological aspects of different WASH project methodologies (e.g. FOAM, CLTS, participatory approaches and social marketing). A.B.C.D. attempts to bring these different sources together in an operational and pragmatic perspective. Its aim is to help develop operational strategies for WASH projects and to reinforce the coherence between infrastructure building, awareness-raising and community mobilization activities. These strategies are based on the analysis of both WASH-related behaviours in the targeted community, and the determinants behind these behaviours. To date, the approach has been tested in four different contexts: two semi-permanent IDP camps in the Central African Republic, peri-urban communities in the Democratic Republic of Congo and rural communities in Bangladesh and Myanmar.

In this article, we will first discuss the main principles of the A.B.C.D. approach, and then to illustrate the approach, we will present some of the results of the study carried out by SOLIDARITES INTERNATIONAL in a peri-urban neighbourhood of Kinshasa.
**A.B.C.D.: 1- Establishing a hierarchy of at-risk behaviours and practices**

As part of the A.B.C.D. approach, based on the available scientific knowledge and the experience of SOLIDARITES INTERNATIONAL, five key behaviours have been retained as having the most impact on diarrhoeal diseases: 1- Washing hands with soap at key moments of the day, 2- Adopting appropriate defecation practices, 3- Keeping latrines and house surroundings free of excrement, 4- Using potable water for drinking and cooking, 5- Collecting, transporting, storing and drinking water in an appropriate manner. Scientific research has established that the risks of diarrhoeal diseases are reduced by 47% if communities have appropriate hand-washing practices. Sanitation programmes can reduce the risk of diarrhoea by up to 36% and operations aiming to improve the quantity and quality of water can reduce the risk of diarrhoea by 20% and 16% respectively. Though other behaviours can have an influence on the risk of diarrhoea (food hygiene, the management of organic waste, household hygiene...), the principle of the A.B.C.D. approach is to focus the available resources on the 5 above-mentioned behaviours as, in the majority of contexts, they will have the greatest impact on cases of diarrhoea.

An initial assessment phase establishes to what extent these behaviours are adopted (e.g. the percentage of the population who get their drinking and cooking water from potable water points). The initial assessment also analyses people’s practices in relation to these behaviours, and particularly practices which could increase the risk of contamination. With regard to hand washing, for example, the assessment establishes whether hands are washed before meals or after going to the toilet, and also the way in which hands are washed: a common at-risk practice in communities in the north of the Central African Republic is to wash hands in a basin of water which is used collectively. Adults first dip their hands directly in the water, without soap, followed by all the other family members in order, from the oldest to the youngest. The last in line are children under 5 years of age, who are the most vulnerable to diarrhoeal diseases and the most exposed by this practice of collective hand-washing. Identifying this at-risk practice helps establish that although it is important to encourage hand-washing with soap, it is just as important to tackle this practice of collective hand-washing.

Once practices have been identified and the occurrence of behaviours has been established, the assessment aims to understand if there is a correlation between at-risk behaviours/practices and the frequency of cases of diarrhoea amongst children under the age of 5. For example, we find out whether there is a significant difference in the number of cases of diarrhoea between families who have drinking water storage containers that are closed in their houses (“doers”) and families whose containers are not closed (“non-doers”). The occurrence of behaviours, the qualitative analysis of practices and the established correlation between behaviours/practices and the number of cases of diarrhoea then make it possible to establish what behaviours and practices potentially have the most impact on diarrhoeal diseases. The operational strategy will thus focus on these behaviours and practices as a priority.

**A.B.C.D.: 2- Identifying the determinants of behaviours**

Next, the A.B.C.D. approach aims to understand the positive and negative determinants of the prioritised behaviours and practices. For example, understanding what motivates families to have hygienic latrines and what may prevent other families from maintaining them properly. There are two distinct groups of determinants: external factors linked to the environment and factors which are internal to the operational strategy target groups (generally mothers).

**Environmental determinants** include, in an initial circle, all the aspects linked to the family: decision-making power, management of the family budget, authority, the respective responsibilities of different family members, the distribution of WASH tasks, childcare, etc. A second circle includes aspects from the community, village or neighbourhood environment: accessibility to water points, health centres, communication channels, demographics, ethnic and religious factors, opinion-makers, livelihoods, accessibility to markets, etc. The final circle includes regional and national environmental aspects: public policies in terms of Health, Education, WASH, Security, exposure to natural disasters, cultural systems, etc.

**Internal determinants** are the result of the psychological and physical characteristics of individuals. We try to establish which of these help or hinder individuals in terms of adopting appropriate behaviours. These positive or negative motivations can be economic, religious, based on security, prestige, privacy, disgust, comfort, maternal love, seduction, etc. The A.B.C.D. approach also aims to identify to what extent individuals know the causes of diarrhoeal...
diseases and how they perceive the severity of these diseases for their young children and the consequences of diarrhoea on the rest of the family. However, the approach is based on the principle that though knowledge of the disease and its severity can favour the adoption of appropriate practices, it is not in itself sufficient to encourage a change in behaviour, due to the greater influence of the other above-mentioned motivators and barriers. The A.B.C.D. approach also explores the extent to which individuals feel capable of regularly repeating behaviours (perceived capacity) and the influence of their relatives, friends and neighbours (injunctive norm). The approach can also look at physical determinants, such as questions of accessibility and physical effort related to WASH practices.

Finally, the assessment tries to identify the most significant determinants with respect to the prioritised practices and behaviours and evaluates the extent to which these determinants exist amongst doers and non-doers. If we establish that there is in fact no significant difference between the two groups for a given determinant, it is presumed that acting on this determinant will have little impact on the behaviour of non-doers. For example, if it appears that families who maintain their latrines in a hygienic manner and those who do not all have an accurate idea of the seriousness and the causes of diarrhoea (here, faeces), it is possible to conclude that classic awareness-raising focused on health will probably have little impact on encouraging non-doer families to keep their latrines in a better state. On the other hand, if we observe that the prestige of having clean latrines is mentioned much more by the doers, we deduce that prestige can be one of the focuses of awareness-raising content in order to incite the non-doers to adopt appropriate latrine cleaning practices.

A.B.C.D.: 3- Developing the operational strategy

The operational strategy will be based on the behaviours and practices which can potentially have the most impact on reducing the occurrence of diarrhoea amongst children under 5 years of age. Analysis of environmental determinants essentially allows barriers linked to the context where people live to be identified (e.g. availability of water, difficulties with communication channels, inter-community tension, insecurity, livelihoods which do not cover basic needs) and to base technical decisions and operations on these.

For example, if there are tensions between different communities (castes) in a displaced persons’ camp in India, installing a single water point in the area occupied by one of the castes will mean that it will be under-used by the other caste. Understanding these social tensions and other environmental determinants will make it possible to choose appropriate sites and technical solutions (in this case, by installing a water point for each community). Analysis of the environment will also make it possible to identify the people who have the most influence over the targeted group, both inside families and in the community. For example, conducting awareness-raising activities with mothers who do not have much authority or freedom of expression within their husbands’ families (generally the case in India, Bangladesh or in the north of the Central African Republic) would be useless if the husband’s family prevents the mother from adopting appropriate practices. In cases like this, awareness campaigns should target both mothers and mothers-in-law (in reality, women between 18 and 45 years old). Detailed understanding of the social environment will allow opinion leaders, potential awareness-raising relays and the most pertinent community mobilization strategies to be identified.

Analysis of internal determinants can have an impact on the choice of technical options. For example, taste is often an essential determinant in the choice of water points for drinking. Thus, installing a pump which draws water from a ferruginous aquifer can lead to the water point being under-used and even abandoned even though the water is potable. Other technical solutions should be given priority (treatment of surface water or reaching aquifers with neutral tasting water). Analysis of internal determinants is also essential to produce awareness-raising and community mobilization messages – c.f. the example of prestige given above as a way of encouraging the maintenance of toilets.

Batumona – methodology of the survey

The survey was carried out in Batumona, a peri-urban neighbourhood of Kinshasa of about 30 500 inhabitants (3 800 families) which is currently going through huge demographic growth. It was funded as part of the Potable Water Supply Pilot Project (Projet Pilote pour l’Approvisionnement en Eau Potable), funded by the French Development Agency, which has installed water networks in 14 neighbourhoods of Kinshasa and the surrounding
areas. The Batumona network was put into operation at the beginning of 2014 and covers the densely-populated zones of Batumona. The most recently occupied area, however, is not well supplied. Its inhabitants are more dispersed, communication channels are either badly damaged or non-existent and plots subject to erosion during the rainy season.

Studies were carried out over a month by a team of fourteen people, eight men and six women, with varied profiles (hygiene, public health, social issues, urbanism, events, marketing, etc.) all of whom were from the neighbourhoods targeted by the project in order to encourage understanding of the environment and ownership of the activities. The team received training in the A.B.C.D. approach and the main principles of WASH activities in parallel to their work on the studies. Three people facilitated the process and analysed the results.

The choice and succession of initial assessment activities was aimed to limit reporting biases and to assess families’ day-to-day realities in as realistic a way as possible. Before beginning the studies, two members of the facilitating team spent three days living with two families in the two neighbourhoods targeted by the project (immersion). An observation visit, two studies on gender and a mapping of Batumona were also carried out in advance in order to improve understanding of the neighbourhood environment and the socio-cultural context in which the inhabitants live. Several studies were then conducted by the teams in the families and at the different types of water point. The studies were conducted with more than 220 families with children under 5 years of age, or around 9% of the targeted population, spread throughout the neighbourhood. The studies were based on a methodology of structured observation complemented by closed questions. The team members were also encouraged to discuss freely the reasons for the observed practices (whether appropriate or at-risk) and note any supplementary and relevant information which was not included in the questionnaire. Each study was discussed in advance with the team. On average they lasted two or three days. A debriefing session on determinants and at-risk practices was organized after the first day and at the end of each study. Lastly, a final study was carried out to check the occurrence of the determinants which had been identified, as well as the variations between doers and non-doers.

**Batumona – understanding and frequency of diarrhoea**

The prevalence of diarrhoea among children under 5 during the two weeks before the study in Batumona was 31% (95% confidence interval: 25.1% - 36.9%), compared to an average of 14.1% in Kinshasa. A focus on families in the five most at-risk streets of Batumona showed that the incidence of diarrhoea was higher, at an average of 48%.

Diarrhoea is perceived as one of the most serious “diseases” for children under 5 years of age. 86% of the mothers who were asked considered that diarrhoea was a big problem for their child and 58% spontaneously spoke of the possibility of children dying as a consequence of diarrhoea. What is more, the mothers spoke of the major source of stress that diarrhoea represents for the family: mothers are “paralysed”, unable to leave their child and unable to work. Families have to spend considerable amounts, equivalent to at least one day’s work, to treat the child. The mothers therefore worry about the repercussions on the other children of the family who they will not be able to feed due to a lack of money. The first cause of diarrhoea that mothers mentioned spontaneously was food, but half also mentioned water as another cause. Only 16% of mothers spontaneously mentioned contact with or ingestion of excrement, but they all replied that this caused diarrhoea when they were directly asked. Thus, the mothers generally had good understanding of the causes of diarrhoea and especially were very conscious of the seriousness of the disease for their children, and indirectly, for the rest of the family.

![Figure 1](image)

**Figure 1 – Distribution of families in sub-neighbourhoods A, B, C and D based on their hygiene practices**

Knowledge of the causes of diarrhoea did not prevent a large number of families from having inappropriate hygiene practices. The study established a clear correlation between the environment of the neighbourhood and hygiene practices: Batumona is divided into four sub-neighbourhoods called A, B, C and D by the local administration. In sub-neighbourhood A (more densely populated, well served by potable water points and easily accessible), 35% of the respondents were doers (families with appropriate hygiene practices, measured by a score of between 8 and 12) and 14% were non-doers (families with at-risk hygiene practices, who had a score of between 0 and 4 out of 12). In contrast, in sub-neighbourhoods C and D (poor potable water coverage, difficult communications and a high level of erosion), 10% of respondents were doers and 25 were non-doers (see graphic above).
The study established a significant correlation between practices and diarrhoea with regard to the cleanliness of latrines, the consumption of rain water as drinking water (collected in a non-hygienic manner) and the hygiene of the drinking water storage container. It should be noted that the study did not establish a clear correlation between hand washing with soap, and children’s diarrhoea. However, this behaviour was selected as one of the priorities of the operational strategy. Indeed, the analysis of hand washing was based only on what the mothers said (being unable to observe what happened) and this is often biased as they are ashamed to admit that they do not wash hands at key moments of the day. The reference for the study was therefore the meta-analyses carried out on the subject [see above].

We will now focus on the consumption of rainwater collected in un-hygienic conditions to illustrate how the A.B.C.D. approach is applied to an at-risk practice.

**Batumona – the consumption of rainwater for drinking and cooking**

<table>
<thead>
<tr>
<th>Rainwater not drunk</th>
<th>Rainwater drunk</th>
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<tbody>
<tr>
<td>At least one case of diarrhea in the last 15 days</td>
<td>27%</td>
</tr>
<tr>
<td>No diarrhea in the last 15 days</td>
<td>73%</td>
</tr>
</tbody>
</table>

97% of the families in Batumona collect rainwater from the roofs of their houses using buckets and containers which are used for various purposes. 90% of these families use the water as drinking water and/or for cooking. However, 78% of families think that rainwater can lead to disease. Amoebas were mentioned by 63% of the respondents, and typhoid fever and diarrhoea respectively by 33% and 27% of the respondents. There is a significant correlation between the occurrence of diarrhoea amongst children under the age of 5 and drinking rainwater (see graphic above). Though rainwater is potable in itself, the roofs and containers which are used to collect it can be full of pathogens (particularly after a long period without rain).

The rainwater collection systems in Batumona vary from household to household, the roofs are not cleaned, the containers are often dirty and 42% of families collect water as soon as it starts raining; these factors certainly explain why this correlation exists.

The main reasons given for using rainwater for drinking that were mentioned during our study were: 1- because of its coolness (pleasure – 22%), followed by 2- it is free (economic – 21%), and 3- it is easy to collect (accessibility – 20%). The other reasons were mentioned in fewer than 15% of cases 4- its taste in addition to its coolness (pleasure – 13%), 5- habit (11%) and 6- because it comes from God (belief – 9%). The divine nature of rainwater, though not spontaneously mentioned very often in this study, was often spoken of with the teams: “God gives us rainwater, it is pure and we must use it”. Amongst all the determinants mentioned above, a significant difference exists between doers and non-doers on the subject of it being free (mentioned by 50% of non-doers vs. 16% of doers), its accessibility (47% of non-doers vs. 14% of doers), habit (29% of non-doers vs. 5% of doers) and belief that it comes from God (11% of non-doers vs. 0% of doers).

The main reasons given for not drinking rainwater were: 1- to avoid diseases (fear of diseases – mentioned by 37% of respondents), 2- because of the particles in the rainwater (disgust – 28%), 3- the poor quality of the water (perception of quality – 14%), 4- because of the smell (disgust/smell – 12%). The size of the response related to preventing disease remained relatively small, if we take into consideration that the majority of the population thinks that rainwater can cause disease. The determinant of disgust (presence of particles) was mentioned relatively often. The only significant difference between doers and non-doers concerns the determinant of smell mentioned by 17% of doers compared to only 3% of non-doers.

**Batumona – operational recommendations regarding the consumption of rainwater**

The main awareness-raising message is to dissuade the use of rainwater as drinking water for children under the age of 5, considering that there are safe water points in the neighbourhood and that many families already give their very young children « improved » water (for example in bottles). Awareness-raising also has to tackle the problem of roof and container hygiene.

Health-orientated awareness-raising will not have a great deal of effect as the vast majority of respondents are already conscious of the problem. However, reinforcing concern about amoebas with that of diarrhoea could provide a small amount of leverage. Accessibility is a major determinant for rainwater consumption. The issue of access can only be tackled by improving coverage by potable water points, notably in sub-neighbourhoods C and D. However, improving access will not completely resolve the problem of rainwater consumption for children under...
five. Indeed, the inhabitants of sub-neighbourhoods A and B consume it despite having easily accessible potable water points close to their plots. It is therefore essential to engage in awareness-raising in the other areas which have been identified.

The motivations which are the easiest to exploit (due to their frequency and the difference between the doers and the non-doers) are economics and disgust. An area to work on would be the perceived cost of illnesses. For example, the cost of treating illnesses like amoebas and diarrhoea could be compared to the money saved by collecting rainwater. Disgust would also be a way of getting families to take notice. As a general rule, the inhabitants of Batumona wash their hands before eating essentially to get rid of the "dirt" stuck to their hands. It would be possible to compare the rainwater collected in a non-hygienic way to the water in the basin which is used to wash hands, and exploit this disgust by showing that drinking the rainwater is like drinking the water from the basin where everyone washes their hands. Disgust could also be exploited by, for example, asking someone to wipe the roof with their finger, then asking them to lick their finger (which they will refuse to do), then comparing this with the rainwater collected from a dirty roof. In terms of the perceived purity of rainwater because "it comes from God", it is possible to get round this belief by focusing on the dirty roof: though the water is pure, the roof is covered in "dirt" (as is the container if it is not washed) and pathogens which pollute the water that is collected. Finally, though it is difficult to exploit aspects related to the taste and coolness of water, they nevertheless show that awareness-raising which promotes water treatment methods (such as boiling and chlorination) would not have a great deal of impact due to the change in taste caused by the treatment (the taste of boiled water is affected by the pot that is used and the people do not like chlorine at all)21. These treatment methods will nevertheless be recommended for drinking water for children under 5 years of age.

**Conclusion**

The example of rainwater consumption in Batumona shows how important it is to understand the factors which determine behaviour: the study established that health is not an area which can be exploited to encourage the adoption of appropriate practices in terms of collecting and consuming rain water. On the other hand, targeting accessibility, household economies and disgust will have a significant impact in terms of changing behaviour. A monitoring phase of several months will nevertheless be necessary to ensure that the new behaviours become firmly established. In order to do this, key messages have to be repeated and families need to be provided with support in order to help them overcome any difficulties they might have to face in connection with changing their behaviour.

The A.B.C.D. approach is based on the targeted communities’ environment and day-to-day lives. On the one hand, it encourages observation and critical analysis on the part of the local team in charge of collecting information, and on the other hand, it forces us to think about the context of the project in order to develop integrated and made-to-measure operational strategies. The A.B.C.D. approach aims to be adaptable rather than a fixed project methodology. Though its main principles are relevant in any context (training and mobilization of teams, focus on at-risk behaviours, analysis of practices, of external and internal determinants, of integrated strategies, support and monitoring of practices), it is flexible and can be adapted depending on the environment, the resources of the project and the level of progress of the activities. The A.B.C.D. approach requires about a month and implies investing the resources needed to carry out the study and developing the operational strategy with the team. However, the principles of the approach are easy to test and can be adapted to each organisation’s own tools and methodologies and can be adopted by any Project Manager who wants to establish the conditions for the sustainable adoption of appropriate behaviours. The aim is also to develop a simplified version of the approach which will be relevant for acute emergency contexts. At the time of writing this article, SOLIDARITES INTERNATIONAL and EAWAG are in the process of testing this area.

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This article will focus on diarrhoeal diseases. However, the main principles of the approach are relevant for determining strategies in relation to any disease or malnutrition.

In the article, "doers" refers to families with appropriate practices and "non-doers" to families with at-risk practices.


However, these results cannot be used without a complementary qualitative analysis, notably due to the interaction, which is difficult to quantify, between 1-behaviours with each other and 2-determinants with each other.

For example, the following was regularly heard in Kinshasa: "It is important to have clean latrines so that visitors see that we are a ‘good’ family".

15 i.e. 61% of families have children under 5, or 220 / (61% x 3800) = 0.094


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Humanitarian assistance in post-crisis urban contexts – what have we learned so far?

Béatrice Boyer & Marion Bouchard

When there is a disaster or conflict in a city, people need a great deal of assistance of a specific nature for which the humanitarian sector is not well prepared. The vulnerabilities of urban populations are added to the deficiencies or fragilities of urban systems and services which should structure cities and make them resilient. Groupe URD has been analyzing the issues involved in post-crisis urban operations for more than ten years. Since the 2010 earthquake which hit Port-au-Prince in Haiti, there has been growing awareness about this issue and we are moving towards a paradigm shift in the humanitarian sector regarding urban assistance with the issue being debated in numerous international bodies.

The vulnerability of cities and urban populations to external risks – natural hazards or wars – is caused by at-risk behaviour and poorly managed or uncontrolled urban development. Yet, humanitarian actors, who are called upon to play an important role during the emergency phase after the crisis, are confronted with local urban methods and the different actors who are present: local civil society, local and national institutions, aid agencies, and development and private organisations. They contribute to the recovery phases and some begin the reconstruction phase. Despite being limited in duration and in terms of mandates, humanitarian action nevertheless has a strong impact on the post-crisis context. But the difficulties of using classic aid mechanisms have led the international community – operators, donors and decision-makers – to reconsider its way of doing things. Numerous debates and attempts to improve practices in urban environments are currently underway at the international level. This article looks at what we have learned so far.

The links between the development of urbanization and the development of crises

Last century, the majority of the world’s population was rural, notably the poorest people. The few big cities that existed – there were 16 cities with more than a million inhabitants in 1900 – were located in developed countries and were synonymous with prosperity. Since then, cities have continued to grow exponentially, in number and in size, and in a more or less controlled manner. Thus, since the 2000s, more than half the world’s population is urban and according to forecasts by UN-Habitat, more than 80% of the urban population will be living in countries in the global South in 2030. As well as being characterized by the concentration of powers, cities are also places where there is a density of activities: economic, employment and educational opportunities, societal and cultural dynamics, access to basic and medical services, etc. Embodying the promise of a better life for everyone, cities continue to attract people before the necessary infrastructure has been created to provide them with decent living conditions. This leads to urban contexts which are chaotic and dangerous, particularly in countries in the South where the majority of mega-cities (with more than ten million inhabitants) are concentrated. Between a third and a half of these city-dwellers live in informal urban areas (slums)².

Cities do not escape crises, and they can even start them. Without going into the history of sieges and urban disasters, or the wars currently taking place in cities (Ukraine, Syria, Iraq, etc.), it is clear that a number of factors can lead to disasters or conflicts: sudden or unexpected hazards, climate change, the proximity of the coast, resource depletion, the absence of technological control, the appropriation of land or resources, etc. According to a Disaster Emergency Committee report (Urban Disaster – lessons from Haiti)³, between three and five urban disasters could take place in the next ten years.

Different factors contribute to the fragility of cities and also to crisis management. Some of these are integral parts of certain cities – uncontrolled population density, lack of awareness amongst the population about risks, buildings which are not adapted to risks, weak institutions, lack of prevention legislation, at-risk geographical location, significant geological and climatic phenomena, etc. –; others are linked to the crisis and the sudden insecurity in the city or nearby, with the displacement of victims to, from and within the city, who make the disorder created by the crisis itself worse and make managing assistance more complicated.

Thus, the scale of the impact of a crisis in a city is such that it not only determines the challenges of the emergency relief operation but also the challenges of the reconstruction.
Questioning post-crisis methods of action

Inappropriate humanitarian mechanisms

Integrated approaches are essential in urban contexts. Emergency relief organisations have had difficulty adopting approaches of this kind, as part of a coherent reconstruction strategy, in terms of competencies, resources and mandates. Successive disasters in cities, such as the earthquake which hit Haiti, and more particularly the city of Port-au-Prince, in 2010, followed by the strong mobilisation of the international community, with more than 3000 NGOs providing emergency relief and reconstruction aid, have highlighted the difficulties, and even the major problems and incompatibility of humanitarian practices with emergency operations in cities.

The limits of sector-based, technical and standardised approaches in a complex, multidimensional territory

The fact that aid programmes are not adapted to urban contexts can be seen in several areas. For example, supplying temporary shelters which are then made permanent raises the question of land occupation and ownership. The free supply of water and food harms local economic forces, whether formal or informal, pre-existing or created by the crisis. Systems for providing basic public services which are maintained as much as possible by the local authorities, such as the health system and sanitation infrastructure, are compromised by the free services provided in parallel by humanitarian organizations. Similarly, the construction of roads, houses and public facilities carried out without coordinating with the local authorities can hinder planning strategies and disturb the balance of the territory.

The assistance that is needed in urban areas during the different phases of the post-crisis cycle – emergency, post-emergency, reconstruction and prevention – raises new issues for the humanitarian sector in terms of their specific characteristics and their scale. The complexity of the city, with the interconnected nature of urban systems, whether political, economic, social or physical (infrastructure, buildings, private and public spaces, etc.), raises questions about humanitarian practices and the need for appropriate mechanisms and expertise.

Crisis in cities mean that aid mechanisms need to be adapted and questions raised about different responsibilities

A coordinated inter-sector and territorialised approach needs to be adopted – One important aspect is spatial understanding of urban issues and the need to operate in a coordinated and coherent manner while identifying the different levels on which a territory functions.

Complexity which needs to be understood and managed – Given the complexity and inter-related impacts in cities, humanitarian actors increasingly have to take action on different timescales: emergency relief, but also recovery action, which includes prevention and preparation. In protracted crisis management contexts many donors allocate new budgetary envelopes for transition and reconstruction phases, giving the humanitarian organizations that are present the opportunity to continue programmes. But, the decisions made during these post-crisis periods have an effect on future development - short term activities with long term impacts. The emergency relief phase is a short and intense period of decisions which bring responsibilities beyond the crisis.

Local legitimacy which needs to be respected – In order to provide assistance for more sustainable, resilient and equitable reconstruction of the city, it is essential to establish partnerships with the local authorities, the difficulty being the type of partnership to establish, the roles to respect and particularly the decision-making methods. As was pointed out by the representatives of Haitian institutions at the World Urban Forum in Medellin in 2014, these initial fundamental decisions for the city are made by the international community. And local actors are not always conscious of how these decisions are made in the general confusion of the emergency phase, or of their consequences in the long term, or why these decisions can create injustices or become more and more difficult to adapt when the situation is changing every day.

There are therefore still changes that need to be made to aid processes in cities.

Beyond the disaster: an opportunity for the city

Crisis reveals structural vulnerabilities and pre-existing problems and inequalities. Aid provides the possibility of strategic decision-making which, in normal circumstances, would require, in addition to the necessary funding, a long period of negotiations and consensus between institutions who do not always want to cooperate. The mobilisation of technical and financial resources should therefore make the post-crisis period a time of recovery and creation of safer cities, and allow development which includes responsibility towards the environment and people. The crisis should also be seen as an opportunity to “build back better”.

The nature of the responsibilities of the different organisations involved in the management of the crisis and the management of the city itself is in question, particularly

Since the 2010 earthquake, everyone is aware of the challenges of urban disasters

Humanitarian Aid on the move Review n°14
the links between these sectors of activity. Efforts are being made by the different urban sectors of expertise and there is a great deal of exchange and discussion about tools at the moment.

**In parallel to developments in the field, particularly in Haiti, the post-crisis city is the subject of debate.**

Changes in humanitarian mechanisms in Haiti since the earthquake of 2010

The urban question and its repercussions in terms of coordination, relations with local authorities, etc. has gradually been taken into account by the different aid structures in Haiti, which has led to the development of programmes which are more adapted to the city. The international community is currently drawing lessons from this in terms of operational strategies for other urban crises:

- During the emergency phase of 2010-2011, the issue of rehousing, which needs to be integrated into urban operations, struggled to gain ground with humanitarian actors. It was only discussed outside the Clusters in sub working groups which focused on Housing-Neighbourhood (Shelter), Housing-Land Ownership (Protection), and the link between housing and basic services (WASH). There was therefore a lack of coordination between sectors across the territory, despite this being essential in urban contexts.

- Between 2011 and 2014, the sector has been making an effort to understand urban realities. UN agencies have tried to support local institutions (both governmental and institutional), technical and decision-making institutions, such as the Support Programme for Housing and Neighbourhoods which focused on Housing-Neighbourhood (Shelter), Housing-Land Ownership (Protection), and the link between housing and basic services (WASH). There was therefore a lack of coordination between sectors across the territory, despite this being essential in urban contexts.

- From 2013, different development donors like the European Commission, the World Bank and the French Development Agency launched neighbourhood development programmes involving numerous emergency relief agencies which led them to adopt a coherent development approach. This was the case for the Support Programme for the Reconstruction of Housing and Neighbourhoods launched by the European Commission which involved operations in several inter-related technical sectors in a single living area, the neighbourhood. These developments show that the operators involved in this programme (NGOs) are adapting their competencies technically and strategically to the urban sector.

- Finally, in 2014, four years after the crisis, the same donors launched studies and evaluations to learn lessons from these changes in practices and programmes. Another example of changes in operational methods in cities is the fact that the strategies of local institutions are helping to make aid programmes evolve so that they take specific urban characteristics into account more effectively. This is the case for the CATUR programme run jointly by UN-Habitat and the local institution, UCLBP. This shows that there has been a change of vision: integrating displaced people into the urban landscape rather than giving them shelter in temporary camps.

**Debating operational methods in cities**

The Urban issues department at Groupe URD has been exploring these issues for a number of years via studies, evaluations, articles and publications. Debated in 2011 during the conference, “La ville face aux crises”, organized at the Paris City Hall, then in 2013 at the seminar, “Cities and crises”, organized in partnership with the French Development Agency, these subjects are becoming increasingly important in the humanitarian domain and in broader discussions about urbanization, which shows that there is growing global interest in them. In addition, the issue of crises in urban environments is also being included in broader discussions about urbanization in numerous forums, beyond the humanitarian sphere.

**At the UN level, the IASC (Inter-Agency Standing Committee) has created a working group, MUHCA, on humanitarian challenges in urban environments.**

In 2009, having recognised that in order to provide people with assistance in cities the humanitarian sector needed to improve its understanding of urban complexity, the IASC created a reference group specifically for humanitarian challenges in urban areas. This acts as a community of practice on crisis management, preparation and response in terms of urban policies, tools and capacity building. This community is open to all organizations (UN agencies, humanitarian and international organizations, donors and academics) who want to contribute to the establishment of a strategy and action plan with regard to urban challenges. Numerous debates are organised to share information about new practices, lessons learned, know-how and knowledge of organizations who are involved in these contexts. The participants in these debates include the International Federation of the Red Cross and Red Crescent (IFRC), UN-Habitat, Groupe URD, the Shelter Centre, the Norwegian Refugee Council (NRC), Concern International, the International Organisation for Migration (IOM) and the British Red Cross.

**ALNAP has created an exchange portal on urban humanitarian response and a community of practice for urban response.**

At the 27th ALNAP biannual meeting, held at the beginning of 2012 in Chennai in India, the participants (including Groupe URD, the British Red Cross and ACF) observed that the international humanitarian sector was
not compatible with the scale and nature of urban contexts. ALNAP subsequently adopted a strategy with the aim of raising awareness amongst organizations about the specific nature of humanitarian action in cities and published a report on the urban question with an online portal dedicated to this subject. A year later, ALNAP founded the Urban Response Community of Practice, an online forum for exchanging experiences, resources and news about the subject. Use of the forum has considerably increased in one year and the community now has 902 members from 81 countries. The United Kingdom and the United States have the most members (250) whereas France only has 20.

In terms of urban development issues globally, the World Urban Forum is slowly opening up to the issue of urban crises.

Having become conscious of the common issues between emergency relief, development, urban development and urban policies, humanitarian actors are taking part more and more in international debates on urban questions.

The 7th World Urban Forum (Medellin, April 2014) – a major international conference on cities and urban development, organised by UN-Habitat in partnership with the host city and government – brought together 22 000 participants including numerous experts from governments, NGOs, civil society, universities, the private sector, donors, foundations, the media, international agencies, etc. The theme of this edition was “Urban Equity in Development” and lasted several days with numerous discussion events with the general goal of examining current global urban issues.

The case of post-earthquake reconstruction in Port-au-Prince was represented by Haitian organisations and international organisations (humanitarian and development) who also have a role to play in establishing the foundations of the reconstruction of resilient and safer cities. A round table on the issue of humanitarian operations in cities organised by UN-Habitat led to the observation that humanitarian organizations lacked understanding of the urban environment.

Developments to expect from future events on urban issues: Habitat III and the World Humanitarian Summit

The participants at this round table called for these discussions to be pursued and intensified at the major international events on these issues in 2016: one on the city (the United Nations conference on housing and sustainable urban development, Habitat III) and the other on humanitarian action (the World Humanitarian Summit). However, in terms of the proposed subjects for the main themes of the World Humanitarian Summit, and the different debates which have begun prior to the summit, it seems that the urban context is still only mentioned in a very marginal way and not seen as a distinct challenge in itself.

Similarly, Habitat III – which will aim to establish a new urban agenda for the 21st century which specifically takes into account challenges related to growing spontaneous urbanisation – does not sufficiently address crises and integrating emergency responses in city (re)construction.

Conclusion

A real effort is underway in the sector to think about and adapt to urban challenges via experimentation with new ideas, practices and funding mechanisms. These new operational methods:

- take into account local institutions and people as stakeholders, and as partners rather than beneficiaries;
- aim to establish multi-partner dialogue between different sectors;
- provide support;
- seek to include local authorities in coordination mechanisms;
- develop tools (participatory planning, at-risk micro-zoning, mapping tools, inter-sector programmes, etc.).

There is greater awareness amongst the different sectors involved in cities (emergency relief and urban sectors), there is more dissemination of information and knowledge sharing, and there is growing experimentation and expertise. Operational strategies in urban contexts are being analysed and directives are being put in place at the strategic level internationally, but significant barriers exist in the field – ethical, organizational, temporal, financial and in terms of expertise and human resources. Cities require a genuine shift in culture and paradigm.

Regarding humanitarian action in crisis-affected cities, a consensus is becoming established between different sectors of activity about the need for better understanding of urban issues, and the need for specific practices which are adapted to the density, spatial tension, specific local governance institutions, the inter-sectoral nature of urban networks and functioning. But beyond the relatively structured city, what of the capacity and mechanisms to provide assistance in affected areas which have the population density but not the minimal urban structure, such as long-term displaced person or refugee camps? The question is all the more critical when these installations cover informal peri-urban areas.

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Bibliography: Cash transfers - lessons learned from using this new form of aid

General

Is Cash Transfer Programming 'Fit for the Future'? - Final Report
CalP, Humanitarian Futures Programme, King's College London, January 2014,

This research was commissioned by the Cash Learning Partnership (CaLP) and undertaken by the Humanitarian Futures Programme (HFP), King's College London. The project intends to understand how changes in the broader global and humanitarian landscape may evolve in the future (up to 2025), and how these changes might shape cash transfer programming (CTP). The analysis examines these issues in the context of ongoing global dialogue on the future of humanitarianism, including the post-2015 Millennium Development Goals processes, the deliberations for the next iteration of the Hyogo Framework for Action, and the World Humanitarian Summit 2016.

Read the document in English: http://www.cashlearning.org/resources/library/403-is-cash-transfer-programming-fit-for-the-future---final-report

Transferts monétaires en situation d’urgence : Les acteurs humanitaires sont-ils prêts pour une mise à l’échelle ?
L. Austin, J. Frize, CaLP, October 2011, 84 P

While there are more and more examples of cash transfer programmes being implemented in emergency contexts, they are rarely implemented on a large scale, in contrast to in-kind responses. This study identifies a certain number of gaps and blockages which are preventing programmes from being scaled up after disasters and makes a certain number of operational recommendations.

Read the document in French:
The special feature of this issue of Humanitarian Exchange, co-edited with Sarah Bailey and Breanna Ridsdel, focuses on new learning in cash transfer programming. While cash is now an accepted tool, and is increasingly being used in humanitarian response, most programmes are small and gaps in analysis and practice remain. In the lead article, Breanna Ridsdel identifies three major areas that need to be tackled if cash is to be used more effectively, particularly in large-scale responses: market assessment, response analysis and coordination.

Read the document in English: http://www.odihpn.org/humanitarian-exchange-magazine/issue-54

Cash transfers in different crisis contexts

Final evaluation of the unconditional cash and voucher response to the 2011-12 crisis in southern and central Somalia

This evaluation provides an independent analysis of the appropriateness, effectiveness, efficiency and impact of the cash response, with a strong emphasis on learning for future humanitarian interventions using cash globally, and in Somalia specifically. The findings should be considered in the context of one of the most difficult humanitarian operating environments in the world, where the dedicated staff of aid agencies took considerable personal risks and organisations took reputational risks to meet a clear imperative to act in the face of catastrophe. As with any humanitarian response, particularly one implemented at scale and under duress, there were many aspects that could have been improved. Thus the evaluation findings are measured given the alternative - the consequences of a failure to act in the face of one of the first famines of the twenty first century.

Read the document in English: http://www.unicef.org/somalia/SOM_resources_cashevalsum.pdf

Review of cash transfer coordination in Haiti following the earthquake of January 2010
D. Kauffmann, Groupe URD, CaLP, mars 2012, 46 P

Cash transfer programmes (cash-for-work, direct cash transfer, coupons) were an important part of the humanitarian response to the January 2012 earthquake, implemented on a large scale to cover the immediate needs of the disaster victims. Inter-agency coordination, initiated by members of the CaLP, was very rapidly organized in parallel, in order to share experiences and good practices.

Two years after the earthquake, Groupe URD was chosen by the CaLP to carry out a review of this coordination mechanism and its interaction with the other coordination systems in order to learn lessons for future emergencies. The project also aimed to support the CaLP’s advocacy work to improve organisations’ understanding, preparation and coordination of cash transfer programmes.

Read the document in English: http://www.urd.org/Review-of-coordination-for-cash

Cash transfers and social security nets

Reducing Poverty and Investing in People: The New Role of Safety Nets in Africa – Case studies in 22 countries
V. Monchuk, World Bank, March 2014, 185 P

The World Bank’s social protection strategy for Africa for 2012 to 2022 highlights the need to establish a solid factual base to back up the preparation and implementation of social protection programmes on this continent. Since 2009, the World Bank has carried out in-depth evaluations of social safety nets in 22 countries in Sub-Saharan Africa. The results of these evaluations as well as other studies, are the object of this regional synthesis which gives an overview of the current state of social protection programmes in Africa and describes how to reinforce these programmes to be more effective in reducing poverty and vulnerability.

Read the document in English: https://openknowledge.worldbank.org/bitstream/handle/10986/16256/9781464800948.pdf?sequence=1

Cash transfer mechanisms are widely used today in the response to the food and nutritional crises in the Sahel. Beyond emergency relief situations, “cash-transfer” mechanisms are also increasingly considered by governments and donors in national poverty reduction programmes, often as part of national social protection strategies and policies. It seemed appropriate to discuss possible improvements to the links between emergency cash transfer programmes and national social transfer programmes with a view to strengthening the resilience of communities in the Sahel.

Read the document in French: http://www.cashlearning.org/ressources/bibliotheque/444-atelier-dchange-rgional-liens-entre-programmes-de-transferts-montaires-durgence-et-filets-sociaux-de-securit-dans-le-sahel----rapport-de-latelier

Cash transfers and new technologies

E-transfers in emergencies: implementation support guidelines
K. Sossouvi, CaLP, May 2014, 104 P

This publication is intended for the field practitioners of aid agencies engaged in humanitarian responses incorporating cash transfers to be delivered through digital payment systems as well as their extended teams in management and programme support functions. It aims to provide basic understanding of cash transfer systems, a framework for evaluating E-transfer options, and advice about using these different humanitarian aid mechanisms.

Read the document in English: http://www.cashlearning.org/resources/library/390-e-transfers-in-emergencies-implementation-support-guidelines

Web sites

Cash Learning Partnership

The Cash Learning Partnership is a consortium of humanitarian organisations (Oxfam GB, British Red Cross, Save the Children, Norwegian Refugee Council, ACF International) which aims to improve knowledge about cash transfer programmes and improve their quality for the humanitarian sector as a whole.

http://www.cashlearning.org

The Transfer Project

In partnership with national governments, research and civil society organisations, including UNICEF, Save the Children UK and the University of North Carolina (Chapel Hill) launched the Transfer Project. This is an innovative research project and a learning initiative which aims to improve knowledge and practices in the field of social transfers in Africa for a number of key sectors.

http://www.cpc.unc.edu/projects/transfer

Consult the full bibliography & consult some guidelines and tools on the Groupe URD website:

http://www.urd.org/Bibliography
Events

Professional training courses by Groupe URD during the last quarter of 2014 (confirmed to date)

- Adopting a quality approach in international aid projects, Kampala (Uganda), 24-25 October (in English)
- Evaluating the quality of humanitarian action, Plaisians (Drôme provençale, France), 3-7 November (in French)
- Introduction to Sigmah, Paris (Coordination Sud headquarters), 2 December (in French)

For information and registration, contact Anna Lear: alear@urd.org

Conferences in Dakar, London, Amman and Bangkok in connection with “Future Humanitarian Financing”

“Future Humanitarian Financing” is an initiative which hopes to bring new ideas and expertise from beyond the humanitarian sector to find solutions to the growing problem of financing the response to humanitarian crises.

This initiative is being led by a steering group which includes CAFOD, FAO and World Vision, on behalf of the Inter Agency Standing Committee’s sub-working group on humanitarian financing. The discussions in Amman (17 November) and in Bangkok (24 November) will be facilitated by the International Council of Voluntary Agencies (ICVA), those in London by the steering group (31 October and 3 November) and the event in Dakar will be facilitated by Groupe URD (26 November).

The aim of these Future Humanitarian Financing events is to encourage creativity in order to stimulate adaptive change in the financing of humanitarian action by confronting different viewpoints from the humanitarian sector and other horizons.

For more information: www.futurehumanitarianfinancing.org

AidEx, 12-13 November 2014, Brussels

AidEx includes conferences, an exhibition, meetings, awards and workshops, with the main objective of allowing the international aid and development community to meet the private sector. The programme of conferences during AidEx 2014 will focus on Innovation in humanitarian aid.

Pour en savoir plus : http://www.aid-expo.com/

9th Journée provençale de la santé humanitaire, 14 November 2014 at Timone Medical University, Marseille

In connection with its 30th anniversary celebrations, the association Santé Sud has decided to look at the environmental determinants of health... Both in the South and the North, harmonious lives depend on health and the environment. Environmental pollution, climate change, unequal access to energy, food and potable water resources, to education and employment, sanitation problems, over-population, rapid urbanization, harmful lifestyles... Though the health of communities is generally improving, human beings are doing more and more damage to the environment on which they and their health depend.

The 9th edition of the Journée provençale will look at the consequences of these changes on our health and will provide decision-makers with ideas for solutions based on experience in the field.

For more information: http://www.santesud.org/sinformer/evenements/jpsh/jpsh2014/9eJPSH.htm

17th edition of the Semaine de la solidarité internationale, 17-23 November 2014

Every year since 1998, on the third week of November, the Semaine de la solidarité internationale in France seeks to raise awareness about international solidarity and sustainable development. Events are organised throughout the country to involve as many of the general public as possible, through discussions, debates and information to encourage greater solidarity in everyday life.

The 2014 edition of the Semaine de la solidarité internationale will take place from 15 to 23 November.

To see the events taking place by region, by theme, etc., see http://www.lasemaine.org/

With increasingly complex and continually changing operational contexts, this event will be an opportunity for the international humanitarian community to address the new challenges facing the sector. NGOs, from the North and the South, such as Médecins du Monde, Action contre la Faim, Secours Islamique France, Groupe URD, and other organizations such as Alternatives Internationales, the Mérieux foundation, and Grotius International will gather on 27 and 28 November in Annemasse in the buildings of the Cité de la Solidarité Internationale. The event is co-organized by Humacoop and the Cité de la Solidarité Internationale.

Six round tables will take place on a variety of topics, such as the international activities of regional authorities, the current military-humanitarian complex, the role of NGOs in conflict zones, ethics and international strategies in the field of health, communication and the responsibility of NGOs, and the impacts of donor demands on NGOs.


**Salon des Métiers de l’Humanitaire, 29-30 November 2014, in Annemasse**

Organised by the Cité de la Solidarité Internationale, the Salon des Métiers de l’Humanitaire is an event which allows those who are interested in everything to do with international aid (humanitarian, development, etc.), from the local to the international level, to meet and discuss.

The Salon des Métiers de l’Humanitaire will bring together around 60 exhibitors over two days and will include a programme of conferences, round tables, workshops and individual interviews.

*For more information: [http://www.salonmetiershumanitaire.org/](http://www.salonmetiershumanitaire.org/)*

**Other international events...**


- Disaster and Hazards Mapping Summit 2014, Manila (Philippines), 4-12 December 2014 ([http://www.preventionweb.net/english/professional/trainings-events/events/v.php?id=36002](http://www.preventionweb.net/english/professional/trainings-events/events/v.php?id=36002))

Groupe URD

Groupe URD (Urgence – Réhabilitation – Développement) is a non-profit research, evaluation and training institute. Its main objective is to help improve humanitarian practices in favour of crisis-affected people.

Further information:
www.urd.org

Humanitarian Aid on the move

Humanitarian Aid on the Move – a bilingual biannual review – aims to share the results of work on important issues currently facing the sector. We regularly invite external contributors and provide links to other publications. To propose an article, contact Jeanne Taisson: jtaisson@urd.org

Further reading on certain topics and full articles by the authors can be found on the Groupe URD website: www.urd.org/Humanitarian-Aid-on-the-move

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