Position Statement

AMSA believes that:
1. The physical and psychological safety of all humanitarian actors and non-combatants involved in humanitarian crises must be protected.
2. Comprehensive disaster risk reduction strategies should be a priority for international stakeholders, national, and local governments, with a robust institutional basis and framework for implementation.
3. Australian healthcare workers and medical students should have access to opportunities for meaningful engagement and quality training in the principles of International Humanitarian Law and humanitarian action.
4. All people affected by disasters have a right to receive the highest attainable quality of healthcare and assistance to ensure basic conditions for life with dignity.
5. Humanitarian actors must uphold the ethical principles and codes of conduct when responding to a humanitarian crisis and providing healthcare services.
6. Humanitarian action does not replace the importance of local preparedness and response, but rather serves to support an overwhelmed local response and committing to empower recipient populations with self-determination and autonomy.

Policy

AMSA calls upon:

1. The Federal Government of Australia to:
   a. Promote the experience and expertise arising from Australia’s history of responding to disasters while recognising that different vulnerabilities, community needs, and governments in foreign nations require tailored disaster responses;
   b. Develop policies which demonstrate commitment, willingness, and the ability to enforce ‘do no harm’ approaches in humanitarian action (including, but not limited to, preventative protection, responsive protection, and remedial protection);
   c. Expand key humanitarian partnerships to include public health, veterinarian policies, and agricultural and environmental health specialists to reflect core principles of One Health and engagement of multidisciplinaires in disaster response and recovery;
   d. Continue to explore effective and evidence-based means of engaging and investing in foreign development and disaster prevention, mitigation, and preparedness in addition to direct financial transactions;
   e. Require transparent reporting and valid evidence that Australian foreign aid and humanitarian funding is contributing to, and enhancing, disaster prevention and mitigation to reduce the demand on disaster and humanitarian response;
f. Address the differences in funding humanitarian actions in rapid onset disasters versus protracted disasters and crises by embedding relevant economic and funding standards in existing accountability frameworks;

g. Prioritise ethical and sustainable aid investment and funding options;

h. Require those receiving foreign aid and investments from the Australian Government to provide transparent and periodic reporting of community, animal and environmental impacts and sustainability;

i. Develop auditable evidence-based and risk-informed standards of disaster preparedness and mitigation to guide and assess foreign funding and humanitarian action;

j. Demonstrate commitment to the Global Compact for Safe, Orderly and Regular Migration and to embed refugee assistance and resettlement into humanitarian response and recovery frameworks. In doing so, we also call upon the Australian Government to demonstrate an ongoing commitment to ensuring that the work of other governments to uphold this compact is not obstructed or impeded by Australian action;

k. Establish and maintain a register of health professionals with the skills to assess and address the specific mental health needs of, and the wellbeing threats experienced by, first responders;

l. Prioritise research into understanding baseline levels of wellbeing threats faced by domestic first responders and how domestic disaster responses modify these risks

2. The State Governments of Australia to:

a. Promote the experience and expertise arising from Australia’s history of responding to disasters while recognising that different vulnerabilities, community needs, and governments in states require tailored disaster responses;

b. Develop policies which demonstrate commitment, willingness, and the ability to enforce ‘do no harm’ approaches in domestic disaster management;

c. Prioritise ethical and sustainable community investments when securing community resilience through targeted vulnerability and risk reduction;

d. Implement collective trauma and mental health care throughout the disaster management strategy, with particular consideration and support provided for vulnerable and marginalised groups;

e. To develop culturally sensitive and robust mortuary and coronial management strategies, in conjunction with emergency management services, to minimise the impact of these disaster management activities on collective trauma;

3. The Federal and State Governments of Australia to:

a. Increase efforts to address climate change in line with disaster risk reduction principles and in keeping with One Health principles;

b. Prioritise investment in prevention and mitigation strategies based on hazard and vulnerability assessments to increase the cost-effectiveness of investments;

c. Commit to restricting resilience discourse and strategies to protect the vulnerabilities of individuals whilst also holding communities accountable for the promotion and inclusion of individuals;

d. Recognise the presence and burden of pervasive threats to first responder wellbeing and mental health threaten Australia’s capacity to respond to domestic disasters;

4. The international community to:

a. Demonstrate commitment to Disaster Risk Reduction by:

   i. Prioritising risk reduction approaches and activities through funding and action;
ii. Acting to address the social determinants of health as pertinent modifiers of risk;

iii. Conducting evidence-based hazard and vulnerability assessments which use meaningful community engagement to establish and understand the relevant needs, strengths, and expectations of the relevant population;

iv. Undertaking mitigation and preparedness activities which demonstrate a reduction in the reliance on external assistance and the potential need for humanitarian action in the future; and

v. Ensuring strong supply chains for healthcare services to provide surge capacity;

b. Adopt and embed the “Build Back Better” model in relevant disaster management and humanitarian response frameworks;

c. Strengthen public health information systems as part of a disaster resilience strategy in order to facilitate the conduction of humanitarian research;

d. Formally recognise International Humanitarian Law in humanitarian frameworks and domestic law, including legislation at the State level to protect the Red Cross, Crescent, and Crystal emblems, and demonstrate a commitment to prosecute citizens who violate International Humanitarian Law in foreign nations, whether operating under the banner of humanitarian actors or otherwise;

5. Humanitarian organisations and actors to:

a. Ensure that operators uphold the Protection Principles, Minimum Standards, and Core Humanitarian Standards, when undertaking humanitarian aid or action;

b. Implement the Sendai Framework for Disaster Risk Reduction in organisational frameworks and demonstrate commitment to upholding the global targets of the Sendai Framework;

c. Ensure that, at the organisational and individual level, the Principles of Conduct for International Red Cross and Red Crescent movement and Non-Governmental Organisations in Disaster Relief is enacted during humanitarian responses;

d. Demonstrate commitment to self-autonomy and the empowerment of recipients of humanitarian action by, at a minimum:
   i. Initiating humanitarian responses only if local healthcare systems and/or resources have been overcome, or are reasonably predicted to be overcome;

   ii. Allowing affected communities to drive recovery activity planning and implementation;

   iii. Providing support according to needs-based assessments, limiting the development of increased long-term reliance on external aid; and

   iv. Ensure marginalised, disadvantaged groups and vulnerable populations are provided appropriate and equitable support and access to recovery services;

e. Develop and deliver rigorous pre-departure training for personnel deployed to perform humanitarian action. Education, as a minimum, should include:
   i. Protections and obligations under international humanitarian law, as relevant to the role of individuals and organisations;

   ii. Cross-cultural awareness;

   iii. Communal living and social skills; and

   iv. Sensitivity regarding socio-political and environmental issues relevant to the region of deployment;

f. Demonstrate commitment to humanitarian worker wellbeing by, at a minimum:
i. Maintaining clear, open dialogue with workers, to involve them in decision making, give ways to voice concerns, and recognise personal and collective achievements;

ii. Ensuring effective debriefing occurs following return from deployment and prior to re-deployment to ensure continued welfare support;

iii. Recognising the importance of debriefing in reducing the incidence of post-traumatic stress in aid workers and constructing policies that ensure high quality, timely debriefing;

iv. Providing humanitarian workers with regular and specific mental health counselling and support services regardless of the nature of deployment, perceived risk of trauma, and self-reported capacity to cope with stressors faced during deployment; and

v. Routinely screening new and existing aid workers regarding baseline threats and supports of mental health, and developing programs to enhance resilience and plan proactively for potentially required supports;

g. Reject the commercialisation of humanitarian volunteering, rather integrating opportunities for volunteering into humanitarian response frameworks which consider, at a minimum:
   i. Obligations to host or recipient communities;
   ii. Respect for operational and economic transparency;
   iii. Acknowledgement of power imbalances;
   iv. Adherence to performance standards; and
   v. Appropriate follow-up opportunities;

h. Consult with local authorities and form strong, trusted relationships prior to engaging in humanitarian work, alongside combating the spread of misinformation;

i. Commit protected funding towards humanitarian health research and to integrate research operations into their response strategies and, in doing so:
   i. Work with global academic institutions to establish frameworks and guidelines for humanitarian and crisis research; and
   ii. Work with and empower local research organisations in communities affected by humanitarian crises to facilitate humanitarian health research in a community-led way;

6. The International Red Cross and Red Crescent Movement to:

   a. Enhance regulations supporting protections in non-armed conflict and remedy international humanitarian law and the emerging responsibility to protect (R2P) concept to provide clear guidance to humanitarian and security actors;

   b. Expand the current international humanitarian law mandates and guidelines to directly and specifically address cyber warfare attacks and urbanisation of conflict;

   c. Develop and provide access to education for key humanitarian actors and stakeholders, including the specific protections and obligations relevant for each group (e.g. armed forces, security protection, health workers, general public);

7. The United Nations to:

   a. Establish international standards for humanitarian governance, including proficiency and qualification standards in staff recruitment, training and supervision, as well as incident reporting and organisational response;

   b. Empower governments receiving humanitarian assistance to monitor the impact of humanitarian actor engagement and service delivery in
order to hold humanitarian actors accountable for deleterious effects to establish health systems and public health;

8. Australian medical schools to:
   a. Educate medical students on disaster management principles, international humanitarian law (particularly as it applies to health workers), and ethical humanitarian practices;
   b. Highlight opportunities for employment or engagement in disaster and humanitarian medicine;
   c. Provide education regarding disaster vulnerability and community capacity as well as promotion of opportunities to become accredited mental health first aid providers to enhance community resilience.

Background

Rather than defining what constitutes a humanitarian setting, disaster and humanitarian nomenclature typically refer to humanitarian crises and complex humanitarian emergencies. Humanitarian crises occur when widespread threats to human life, safety, health and well-being result from a range of different precipitating, exacerbating, and perpetuating factors.(1) The United Nations (UN) defines a complex humanitarian emergency (CHE) as a humanitarian crisis in a region (whether geographically, politically, or socioeconomically defined) in which human suffering results from the consequences of total or considerable breakdown of authority due to conflict.(2) A CHE typically requires a targeted and coordinated international response extending beyond the mandate, capacity, or jurisdiction of any single and/or ongoing UN country program.(2) Globally, four continents have recently experienced, or continue to experience, one or multiple CHEs, with only Australia and North America free of the direct impact of these crises.(3) Although there are a range of significant contributing factors, disasters are a major contributor to the development of humanitarian crises and CHEs.

Disasters are diverse in their origin and nature but there are several commonalities that are key to defining what constitutes a disaster. An adverse, or extreme, event reaches the threshold of a disaster when it causes such serious disruption of community or societal function that widespread human, material, economic, and environmental losses result.(4) Another core characteristic of disasters is that the event, its impact, and the response required to address it exceed or overwhelm the ability of the affected community or society to manage it within the scope of existing frameworks and resources.(4) While there are several different approaches to classifying disasters, they are generally clustered into:(5-7)

1) Man-made disasters, including accidental and non-accidental, which are further divided into:
   a) Socio-technological disasters including technological, transportation, or infrastructure-based disasters, and
   b) Warfare, which is further classified by distribution and whether conventional or non-conventional methods have been deployed;

2) Natural disasters, which are further divided into:
   a) Climatological disasters including heat waves, cold waves, droughts, and wild and land fires;
   b) Geophysical disasters including earthquakes and volcanic eruptions;
   c) Hydrological disasters including floods and avalanches;
   d) Extra-terrestrial disasters including meteorite, asteroid, and space debris impacts; and
   e) Biological disasters including epidemics, insect manifestations, and animal stampedes.
The increasing frequency of significant natural and meteorological events which, in part, is attributed to climate change introduces the concept of One Health to disaster and humanitarian crisis management. One Health describes a philosophy and approach that recognises that human health, animal health and environmental health are interconnected and that successful management of one sector is dependent upon the others. One Health therefore involves applying a coordinated, collaborative, multidisciplinary and cross-sectoral approach to address potential or existing risks that originate at the animal-human-ecosystems interface. The complex interaction between climate change and deforestation, animal migration and forced cohabitation of multiple species in a single habitat, and urbanisation with increased human population density demonstrates the concept of One Health when considering how these factors contribute to zoonotic pathogen outbreaks of pandemic potential.

As noted, disasters are diverse in their nature, often requiring specialised and targeted disaster management approaches and interventions. Disaster management is an integrated process of planning, organising, coordinating and implementing measures that are needed for effectively dealing with its impact on people. The comprehensive approach to disaster management comprises four phases: prevention, preparedness, response and recovery (PPRR) to ensure a balance between the reduction of risk and enhancing community resilience, whilst ensuring effective response and recovery capabilities. This policy document aims to use this framework to approach how to best deliver healthcare in areas of humanitarian need.

The Australian context.
In Australia, humanitarian action and foreign aid funding is led by the Department of Foreign Affairs and Trade in partnership with several existing partnerships with government and non-government actors. The core function of Australia’s humanitarian aid is to primarily promote its national interests and regional stability through targeted approaches promoting sustainability, encouraging economic growth, and reducing the impact of poverty. Significant portions of aid funding and investment occurs within the Indo-Pacific region due to its strategic importance, geographical relevance, dense population, and vulnerability to natural and other disasters. However, key bodies reinforce that these strategic interests should not limit Australia’s investment or capacity to undertake humanitarian action beyond this geographically refined region. While not comprehensive, this briefly provides essential background prior to discussing Australia’s approach and commitment to disaster and humanitarian crises management globally.

PREVENTION AND MITIGATION

Humanitarian crises are becoming more frequent and complex, particularly in relation to climate change, but still often arise following a triggering disaster or event. Globally, between 1991-2005, 3.5 million people were affected by disasters, with economic losses totalling US$1,193 billion. Communities and populations experience a disaster when they experience human suffering due to underlying vulnerability and poorly managed hazards. To counteract vulnerability and hazard exposure, populations and communities can undertake prevention and mitigation activities. Prevention, in the disaster and humanitarian crisis context, includes all activities which collectively prevent disasters from occurring. Mitigation, by comparison, consists of activities and measures undertaken to minimise or limit the impact of disasters if, or when, they occur. Therefore, although prevention and mitigation have different impacts on disaster impacts (prevention avoiding an impact, mitigation reducing the severity of the impact), both are important protective measures in the context of disasters.

Evidence-based prevention and mitigation.
Of the four major phases within the disaster management cycle, governments have disproportionately focused the majority of disaster funding and action on response.(19) In Australia and the US respectively, only 3% and 4% of disaster spending is allocated towards disaster mitigation.(20) Despite this trend, effective prevention and mitigation significantly reduce costs associated with responding to disasters and rebuilding economic, social and physical infrastructure; for every $1USD spent on risk reduction, $4USD is saved.(19) It is suggested that a greater focus on disaster response and recovery may stem from a lack of tangible revenue generation from the funding directed to mitigation programmes.(20) Therefore, it is poignant for governments to consider and aim to exploit the economic and sustainability benefits of effective disaster risk reduction and mitigation.(21)

A critical activity when undertaking disaster risk reduction is hazard and risk assessment. Specifically, disaster risk reduction requires relevant hazards to be identified, population vulnerabilities to be examined and quantified, and priorities for hazard and risk reduction activities to be established.(22) In establishing these priorities, community participation and engagement is critical as it supports all key stakeholders to understand community priorities and vulnerabilities and identify ways to build community capacity.(22) Therefore, prior to planning or undertaking risk and hazard management activities, communities and stakeholders should undertake the following:(22)

1. Hazard assessments which require stakeholders to:
   1. Identify and characterised relevant hazards (including their nature, cause, distribution, frequency, severity and potential consequence), and
   2. Utilise hazard data such as geological mapping, satellite imaging etc.;

2. Vulnerability assessments which require stakeholders to:
   1. Address the social determinants of health, including pertinent economic, social, demographic, political and psychological factors,
   2. Perform vulnerability analysis, and
   3. Consult the community and participate in meaningful community engagement.

Globally, accelerating population growth coupled with rapid urbanisation and unaddressed social disadvantage is contributing to vulnerability by perpetuating gender inequality, natural resource depletion, and demographic shifts.(12) In addition, climate change exacerbates community vulnerabilities, requiring significant multidisciplinary consultation and engagement in order to undertake effective prevention and mitigation activities.(19) This requires a collaborative effort across social sciences, humanities, natural sciences, health and public health sectors, and civil engineering, integrating different perspectives and knowledge, and using this combined experience and knowledge to drive disaster preparedness policies and action.(19)

Important stakeholders in disaster prevention and mitigation are the governments and local institutions who are responsible for the safety of their citizens.(23) Nonetheless, many governments fail to recognise the importance of hazards and vulnerability, therefore underestimating the benefits of prevention and mitigation to national development.(22) This is reflected by the significant and systemic lack of investment in such programmes; therefore, the integration of disaster risk reduction into national legislation, policy and planning frameworks is necessary if governments are to achieve meaningful disaster prevention and mitigation.(12) This requires extensive infrastructure and skills that many low-income countries lack even prior to being affected by disasters. Therefore, the United Nations (UN), World Health Organisation (WHO), international communities and relevant bodies are often relied upon to assist governments affected by disasters or humanitarian crises.

**Australia’s contribution to prevention and mitigation.**
Disaster risk reduction, achieved through engagement and interaction with public and private sector stakeholders and promotion of scientifically-informed multi-hazard approaches, is reported as a key objective of humanitarian action undertaken by
Australia’s foreign aid policy and spending reflect the belief that supporting growth within private sectors stimulates overall economic growth enhancing the capacity for engagement in disaster prevention, mitigation, and preparedness. Importantly, funding should address vulnerable groups within the population, with Australian policy outlining commitments to ensuring aid funding increase employment and empowerment of women. In aiming to use foreign aid as a means of enhancing disaster preparedness and impact disaster mitigation internationally, Australian priorities include: building infrastructure; facilitating international trade; key industries including agriculture, fisheries, and water; education and health; and addressing gender and other inequalities.

Development assistance and aid funding can assist foreign governments to increase their disaster prevention and mitigation strategies, including enhanced capacity to protect their population. Additionally, Australia’s humanitarian aid, funding, and action should account for the provision of protection to citizens in which the principles of preventive protection are deployed to minimise physical threats or harm. Overall, humanitarian action should increase the capacity for the recipient populations and governments to engage in meaningful mitigation and preparedness activities, enhancing self-efficacy and reducing the potential requirement for further humanitarian action in the future.

PREPAREDNESS

Disaster preparedness comprises the full spectrum of activities, undertaken prior to a disaster or crisis, which enable a government or population to respond effectively to a disaster. Such activities may include the development of evacuation plans, emergency operation plans, plans for disaster response and recovery, and forecasting and warning systems, as well as preparing to undertake rescue and relief operations. Although relevant for all stakeholders, health systems which undertake effective and meaningful preparedness activities demonstrate increased capacity to address the vulnerabilities of their population and minimise morbidity and mortality impacts arising from disasters and crises.

In an acute humanitarian crisis, affected health systems need to facilitate effective, timely, appropriate, and responsive action to prevent unnecessary contributions to morbidity and mortality following a disaster. Such actions specifically need to be responsive to the specific needs, cultural considerations, and preferences of the communities that they serve, particularly those who are disadvantaged or marginalised. Achieving this requires centralised coordination that ensures appropriate healthcare coverage, resource allocation and service provision in response to an acute event. This also requires health systems to have strong supply chains capable of providing significant surge capacity, including plans for providing continuing essential medicines, adequately trained health workers, safe and operational health facilities and the uninterrupted provision of basic healthcare services in disaster settings.

Barriers to facilitating effective disaster preparedness among health facilities include system and process rigidity, optimism bias, poor communication pathways, conflicting messages, and reliance on health systems that are potentially flawed in standard operation to perform in crisis contexts. Additionally, while literature strongly emphasises the importance of preparedness, little clarity is given regarding what constitutes effective preparedness standards, serving as a barrier when requiring health systems to undertake preparedness activities. Risk perception may also be inadequate, as impact severity, rather than likelihood, remains the strongest predictor to efforts to improve community preparedness.

The Australian National Strategy for Disaster Management advocates for action-based resilience planning that strengthens local capacity and capability, places a greater...
emphasis on community engagement, and highlights improving understanding around
the diversity, needs, strengths and vulnerabilities within communities.(29) Where
preparation is a social norm, a community fosters individual and group actions that seek
information, resources, support and aids for monitoring preparedness levels, and
allows individuals and communities to take charge in planning and actioning out
activities in lieu of potentially interrupted emergency services.(28) The Australian
Generative Framework for Community Engagement for Preparedness identifies a
structural approach for the adoption of community engagement in preparedness
activities in Australia and globally.(28)

RESPONSE

Responding to a disaster requires key stakeholders to undertake appropriate actions
and measures in immediate anticipation of, and in direct response to, disasters to
minimise the effect on people while providing immediate relief and support.(11) The
ultimate goal of a disaster response is to save lives, reduce morbidity and protect critical
infrastructure.(11) Common activities undertaken in response to a disaster or crisis
include the provision of food, water, sanitation, health services, shelter and the
protection of civilians.(25)

The ultimate responsibility to respond to a disaster lies with the affected local or regional
government. In instances where initial emergency response capacity is exceeded, local
systems may require external input to adequately respond. In such instances,
estoration of the emergency response should be tiered and progressive, starting at the
most local level and escalating internally before requesting external assistance.(30)
Therefore, while a humanitarian response may become necessitated, such a response
is not a standard disaster management activity. It is important to emphasise that any
external aid provided, must assist the community in managing its own recovery and
building their disaster resilience.(27) This method demonstrates cost-effectiveness and
improves the quality of the national responses through building both institutional
capacity and human resources.(31) Humanitarian action must address the root causes
of the crisis, factors exacerbating the crisis, and factors perpetuating the crisis.
Important root causes may include conflict, climate change, or an isolated disaster, and
important contributing factors may include social inequalities.(15)

In terms of funding, it is critical that economic support for humanitarian responses to a
new crisis does not directly or indirectly impair existing funding or action that is being
directed towards an underlying or coexisting humanitarian crisis.(25) Similarly, it is
imperative that resources from the healthcare system are not entirely re-directed to the
new crisis causing the interruption of ongoing treatment and care.(27)

Humanitarian Healthcare Governance.

Humanitarian healthcare governance is a concept necessitated by the frequent lack of
oversight and accountability imparted upon international humanitarian organisations.
Appropriate governance standards and systems exert substantial influence over
healthcare provision, health facility operation, healthcare provision standards, the
degree of independence from governments.(32) Importantly, they shift accountability
and oversight onto the relevant organisations and key actors themselves.(32)

The efficacy of organisational governance, contributed to by international bodies
including, but not limited to, the International Federation of the Red Cross (ICRC),
Medicins San Frontieres (MSF), and World Vision, are debatable. Despite commitment
to high-quality and robust governance measures, many elements required are
significantly lacking. Notably, these deficits relate to de-prioritisation of care quality
when faced with limited resources, detrimental organisational culture, implementation
limitations, lacking evidence to inform crisis standards, and lacking distinction regarding
accountability and oversight. Other factors that undermine organisational governance
include a culture of underreporting, deficits in systemic quality assurance, narrow and
inflexible auditing processes, the absence of training prioritisation and resultant deficits in expertise and competence, and a lack of effective and meaningful feedback uptake.(32)

**Australian humanitarian response.**
The aim of humanitarian action undertaken by Australia is to increase international disaster preparedness and response, especially within the Indo-Pacific region, while simultaneously advocating for adherence to International Humanitarian Law.(12) Once the decision to undertake humanitarian action is made, the Australian Government calls upon existing relationships with a wide range of partners. These include the Australian Defence Force (ADF), Australian Federal Police (AFP), State and Territory governments, humanitarian specialists, Australian Red Cross, UN organisations and several other government and non-government organisations.(12)

In general, the type of humanitarian action required will determine which Australian partners respond. If civilian protection during an armed conflict is required and civil violence may occur, the humanitarian action may fall to peacekeepers supplied and led by the Australian Defence Force.(24) By comparison, if protection is required in the context of genocide, ethnic cleansing, crimes against humanity and war crimes, humanitarian action is led by DFAT with support from AusAID who work to reduce risks the impacts associated with violence, deprivation and exploitation.(24) The responsive protection actions of these Australian partners should prevent ongoing violations or threats to safety due to violence or human rights abuses.(24) In order to uphold ethical humanitarian standards, humanitarian aid should not result in dependency on having continued such investments or negatively impact labour forces. However, the Australian government claims that there is no valid evidence that undertaking social protection activities in low and middle income countries causes this.(33)

It should be noted that according to the principles of humanitarian action, the involvement of the ADF as a military humanitarian actor would only be ethically justified if certain criteria are upheld. These include: if there is no civilian alternative possessing the required capability; the affected country has made a request for assistance that will compliment other humanitarian actors; there will be no costs to the affected country; the action occurs within a limited timeframe; and the action does not promote the development of dependence upon Australian military forces.(34)

**Voluntourism in disaster and humanitarian responses.**
Voluntourism is the term given to any assistance rendered by tourists or temporary visitors to the region with a stay of less than one year.(35) Ideally, voluntourism should seek to promote the construction of tourist spaces that generate benefits for all stakeholders. Such benefits may include cross-cultural understanding, tolerance building, dispelling of stereotypes, and the exchange of values between individuals and communities. However, commercialised volunteer tourism has received criticism surrounding its ethical validity as it often fails to pursue the relevant needs of the community and can bring greater disadvantage than benefit.(35) Without adequate formal training, tourist-based volunteering carries the risk of remaining insensitive to local needs and customs, cultural misunderstanding, reduction in local knowledge, promotion of community dependency, and irreparable damage to local economies.(35) Voluntourism programs have also been criticised for frequent failures to protect dignity, and exploiting vulnerable communities, in social and public media.(35)

Voluntourism frequently fails to address systemic problems predisposing community vulnerability, and the short-term timeframe of the work can perpetuate local oppression and reduce community self-sufficiency.(35) Programs are also highly susceptible to exploitation and corruption where external aid paradoxically contributes to the magnification of community inequality and marginalisation.(35) Best-practice guidelines for short-term volunteer opportunities focus on pre-implementation consultation with host communities, proactively addressing power imbalances, respecting agency and reciprocity, establishing systems to maintain financial and
Humanitarian action standards.
For international operations, there are a series of standards and codes of conduct guidelines that ensure humanitarian aid is ethical, appropriate and effective. The Principles of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organisations (NGOs) in Disaster Relief outlines ten principles humanitarian workers should follow during any humanitarian response. These principles ensure healthcare is provided free of discrimination, builds local capacities and provides accountability. It also emphasises the need to treat people with dignity, be culturally respectful and not use humanitarian action as a tool for personal, religious or political gain.(36) Additionally, the Sphere Handbook has a comprehensive and extensive section on healthcare humanitarianism action standards with a particularly relevant section on Protection Principles which support the right to dignity, humanitarian assistance, protection and security. It outlines the role and duty humanitarian actors play in protecting people and providing safety and assistance.(27)

Furthermore, the Core Humanitarian Standards are a series of behavioural standards that humanitarian agencies and actors should uphold. If upheld, these standards ensure that any humanitarian response is appropriate, relevant, effective and timely. Additionally, action must avoid negative effects, particularly having communities become dependent on foreign aid. As such, the standards ensure that the response strengthens local capacities and builds community resilience to mitigate this. Furthermore, it promotes the concept of having the humanitarian response evolve and continuously adapt via having inclusive feedback systems. Alongside this, the standards require that staff receive appropriate support and are provided with equitable training. The standards also ensure that resources are managed and used only for their intended purpose, which can be coordinated by central bodies and stakeholders to ensure equitable distribution and coverage.(27)

The Sphere handbook also provides the ‘Minimum Standards’ that should be achieved in a humanitarian response. There are four domains which should be addressed with a series of standards that should be reached for each:(27)

1) Water supply, sanitation and hygiene promotion
   a) These standards promote the right to adequate water and sanitation and decrease the incidence and morbidity of diseases associated with poor hygiene, such as diarrhoeal and infectious diseases.

2) Food security and nutrition
   a) These standards promote the right to adequate food and nutrition, as undernutrition can impair crisis recovery and increase individual and population vulnerability.

3) Shelter and settlement
   a) Having appropriate shelter reduces exposure and can save lives, as well as provide dignity, livelihood and security.

4) Health
   a) Aim is to reduce excess mortality and morbidity through providing critical, life-saving care, alongside health promotion, treatment, prevention, rehabilitation and palliative care.
   b) These standards also emphasise the need to ensure that ongoing medical treatment is not interrupted such as maternal health, HIV, diabetes etc.

International humanitarian law.
International Humanitarian Law (IHL), as enacted by the International Committee of the Red Cross (ICRC), was built on the four Geneva conventions of 1949 for most of the world’s states to limit the effects of armed conflict on individuals who are not or no
longer directly involved in the hostilities of war.\textsuperscript{(37)} In turn, the International Red Cross and Red Crescent Movement and the emblems used as protective markings, is developed from the ICRC.\textsuperscript{(38)} It extends further to restrict the means and methods of warfare and functions to monitor, deliver and protect the weakening of IHL as outlined in the Appendix 3.\textsuperscript{(37,39)}

IHL in disaster response.
The protection of humanitarian workers under IHL covers medical personnel and extends to individuals involved in the transport, administration, collection, transport or removal of patients, sanitary establishments, prevention of disease and medical services as well as religious personnel and civilians not involved in the hostilities of the conflict.\textsuperscript{(37)} This further extends to hospitals, ships, transport vehicles and other infrastructure involved in the delivery of humanitarian aid.\textsuperscript{(38)} This protection is also offered to those who are no longer involved in combat (\textit{hors de combat}); however, humanitarian workers are distinctly identified by the red crescent or red cross emblem whereas \textit{hors de combat} are not.\textsuperscript{(38)} In addition to protections, humanitarian healthcare workers captured by the enemy are not considered prisoners of war and must be released in order to continue carrying out their humanitarian duties.\textsuperscript{(37,39)}

Under IHL, if during an armed conflict, the civilian population lacks the essentials needed for survival, the party is obligated to facilitate the provision of humanitarian assistance.\textsuperscript{(40)} Moreover, no interference should be made by either party in the delivery of care.\textsuperscript{(40)}

Medical personnel responsibilities.
Respecting and acting in accordance with International Humanitarian Law while undertaking humanitarian action is a key measure of good humanitarian donorship.\textsuperscript{(25)} Humanitarian workers are obligated to act in accordance with IHL by treating all the wounded and sick humanely, without discrimination or abandonment, and pose no threat to any subjects or engage in the hostilities of the armed conflict.\textsuperscript{(41)} Additionally, they are encouraged to educate authorities of their obligations under IHL to protect healthcare personnel, infrastructure and civilians whilst acting in accordance with health-care ethics and all legal obligations.\textsuperscript{(41)}

Limitations of IHL in response.
IHL does not apply when the conflict is not classified as armed or is not between two or more states, but rather internally within one state.\textsuperscript{(40)} In instances where the threshold of conflict does not meet this definition, International Human Rights Law (IHRL) and domestic law applies.\textsuperscript{(41)} The application of IHRL and domestic laws is continuous even when unrest is not occurring.\textsuperscript{(40)} See Appendix 3 for comparison of IHL and IHRL. Other limitations of IHL include that it does not regulate the use of force, does not cover internal conflict or isolated acts of violence, and only applies once conflict has already begun, complicating the protection of persons who would normally be protected under IHL.\textsuperscript{(37)} Additionally, new forms of conflict through urbanisation and cyber warfare and the war on terror are not always under the legal jurisdiction of IHL in its current form.\textsuperscript{(42)}

Responsibility to Protect Doctrine
The Responsibility to Protect (R2P) Doctrine, adopted in 2005 by Member states of the United Nations, is to protect populations against genocide, war crimes, ethnic cleansing and crimes against humanity.\textsuperscript{(43)} This extends a responsibility to the international community to ensure protection against these atrocities is undertaken with diplomatic, humanitarian and other peaceful approaches;\textsuperscript{(43)} however, the use of force may come to be justified to ensure these protections as a last resort.\textsuperscript{(44)} R2P, while universally applicable, is not a legally binding principle, does not outline how states fulfill their responsibilities, and its relevance in humanitarian emergencies or disasters is yet to be established.\textsuperscript{(44)}

Urbanisation of armed conflicts.
Increasingly armed conflicts are extending into urban areas and, even if not directly targeted, the services to sustain life are disrupted. IHL prohibits attacks on civilians, civilian objects and indiscriminate targets as harm may incidentally impact civilians. However, criticisms arise in relation to psychological harm and disease that may occur from an attack. Whilst prohibited if foreseeable, effects may be less accurately anticipated. ICRC calls for evolving research and understanding of the practice of combatants in or near to urban areas that may impact mental health and psychosocial needs for harm mitigation to be addressed.

Cyber warfare.
Cyber warfare is prohibited under IHL only in armed conflict to prevent the disruption to critical infrastructure and services for the civilian population and extends to the misuse of data by warring parties, and the spread of misinformation. Debate has arisen about the use of cyber warfare in the absence of violence that does not physically destroy or damage military or civilian infrastructure and the application of IHL.

Other criticisms of IHL.
Criticisms of IHL have called for expansion on what constitutes armed conflicts or to expand IHL framework to cover non-armed conflict including the consideration of the war on terror. Additionally, while most states are bound to the legal obligations outlined in IHL, the implementation is difficult during times of extreme violence. Recommendations to facilitate the effective teaching and implementation of IHL is educating armed forces and the public on the domains of IHL, continue to enact laws that both punish violations of IHL and protect the red cross and red crescent emblems.

Overall, IHL faces significant limitations in guaranteeing the protection for humanitarian actors. This is due to its reliance on all parties upholding their obligations, an inability to oblige a party in breach of IHL to remedy their actions, and its relative reliance on retrospective and judicial review and condemnation of actions for which consequences have already been experienced. This can serve as a barrier for preparedness in terms of confidence in protection and willingness to participate in humanitarian action.

RECOVERY

The United Nations International Strategy on Disaster Reduction (UNISDR) defines recovery as the "restoration [and improvement] of facilities, livelihoods and living conditions of disaster-affected communities, including efforts to reduce disaster risk factors". Importantly, recovery represents a transition from the provision of immediate relief to ensuring more long-term sustainability, not only through the reconstruction of essential services, but also by increasing capacity to respond to future crises. Engaging with local governments to create recovery plans ensures that communities that are already susceptible to political or economic instability are strengthened, therefore mitigating the cumulative impact of subsequent crisis events. In other words, while recovery may take months or years, it is vital because it precedes, informs and reinforces prevention strategies.

Recovery and essential recovery activities.
Although international humanitarian aid organisations can complement recovery efforts, outcomes are better when the affected community can express a high level of self-determination, autonomy and actively contribute to the planning and implementation of recovery activities. Humanitarian standards continue to reinforce the importance of recovery being lead by the local institutions, with foreign actors only taking significant steps if national capacity is insufficient. When international agencies are involved, however, recovery should centre on a needs-based paradigm, wherein excessive or unnecessary provision of resources is avoided through early planning. This ensures that resources are not used counterproductively, and places...
greater emphasis on community-lead solutions rather than promoting an over-reliance on external aid.(30) Essential recovery activities include restoration of healthcare infrastructure, temporary housing arrangements, psychosocial support programs, and health and safety education, amongst others.

An evidence-based approach to increase post-disaster resilience is the United Nations' Building Back Better strategy, which aims to integrate disaster risk reduction measures into "restoration of physical infrastructure and societal systems, and into the revitalization of livelihoods, economics and the environment".(49) By focusing on three key phases of recovery, reconstruction, and rehabilitation, this framework has had marked success in preventing deaths, re-stimulating economies and reforming community mental healthcare in disasters.(50) Additionally, the Sphere Handbook recognises that special considerations should be allocated for marginalised and disadvantaged groups to ensure they are given equitable recovery support, especially in crises where inequities are magnified.(27) In particular, early and ongoing healthcare service involvement is necessary to ensure that community health needs continue to be met. Some suggestion has also been made that post-disaster assistance tends to end too quickly and suddenly, and that a gradual multi-phased withdrawal would be preferable.(22)

When considering recovery from a complex humanitarian crisis featuring conflict and breaches of human rights, peacekeeping functions become a key activity in facilitating recovery. Peacekeeping is a term used by the United Nations(51) and the Australian Civil-Military Centre(34) to describe interventions and activities to preserve achieved peace within a nation or region once fighting and hostile conflict has become settled, regardless of how fragile this cessation may seem. Peacekeeping operations may include observation and reporting on the conduct of all involved parties, supervision over cease-fires or similar peace agreements, and activity as a neutral buffer to support continued engagement of all parties.(51) During such peacekeeping activities, military operators engaged in peacekeeping have strict rules of engagement and must act in accordance with the principles of peacekeeping operations, notably limiting the use of force to self-defence and the defence of the peacekeeping objective.(34) These operations also require consent from the host nation/s, transparent impartiality, and absolute adherence to the established rules of engagement.(34,51)

**Humanitarian actor wellbeing.**
In general, deployment into humanitarian crisis settings predisposes healthcare workers to severe psychosomatic distress, including increased anxiety, depression and burnout, alongside decreased life and job satisfaction.(52) More worryingly, these effects tend not to be self-limiting in a significant majority of repatriates, and can persist for several months post-deployment.(52) While the average worker will experience at least one acutely traumatic event during their deployment, routine exposure to sources of chronic stressors tends to have a more cumulative psychological effect, such as living in unstable areas, lack of direction and an excessive workload. As a result, workers with an established history of mental illness tend to be more prone to these effects.(52)

Unfortunately, aid workers tend to minimise their distress or resist support due to their perception of the ‘culture’ of humanitarian work, and organisations themselves do not provide counselling or support unless it is expressly requested. Consequently, some workers engage in self-destructive, dissociative behaviours such as drinking excessive alcohol when working overseas.(53) Alongside occupational stressors, humanitarian aid workers’ perception of the organisational support they receive has a strong correlation with mental wellbeing, with factors like under-supervision, lack of communication and lack of appreciation aggravating pre-existing anxiety.(54)

Attacks on healthcare workers are also numerous, with 808 total attack victims recorded from 1997 to 2019 who were either killed, kidnapped or wounded during their deployment.(55) In the highest incidence contexts, such as Syria and South Sudan,
attacks ranged from aerial bombardment to bodily assault, kidnapping, rape or sexual assault, especially female nurses, shooting and explosives, amongst others.(55) While the majority of perpetrators that attack healthcare workers are state or non-state armed forces, involvement by criminal groups and individuals is significant, motivated by factors centring around miscommunication early on in international partnerships, such as rumours, language barriers and improper handling of the deceased.(55)

Although pre-deployment debriefing has been shown to reduce the incidence of post-traumatic stress experienced by healthcare workers,(56) these programs are either absent or inappropriately implemented by many humanitarian aid organisations. The best available evidence provided by literature reviews show that PDBs enable workers to prepare for the anticipated stress of working in an environment with a lack of socio-cultural support, especially with the addition of cross-cultural training modules.(57) However, NGOs tend to rely instead on aid workers having intrinsic motivation and initiative to read about their future host country and undertake independent preparation, such that only one-fifth of workers receive any PDB, and just 7% found it to be adequate.(57) Given the post-assignment to re-deployment period is where aid workers are most likely to ‘fall through the cracks’ in terms of health, wellbeing and preparedness,(58) this is surmised to be the time where systematic debriefings would be the most effective.

RESEARCH

Humanitarian health research has been recognised as a priority in lifting the quality, and minimising the potential negative impact, of humanitarian healthcare practice; however, there is currently a significant lack of evidence to inform public health interventions in humanitarian crises.(6) Available evidence is criticised for being methodologically flawed, derived from anecdotal evidence, or derived from stable and high-income settings that significantly differ from those seen in humanitarian crises.(6)

Despite the significance and relevance of humanitarian research, there are numerous barriers to the effective conduction of humanitarian research. On an organisational level, humanitarian actors are often overstretched and underfunded, leading to the de-prioritisation of research.(6) Additionally, health and public health information systems are often disrupted and/or politically-biased, limiting opportunities for safe and satisfactory systematic data collection, analysis, reflection and dissemination.(6) Researchers are often asked to perform in low-resource, unstable and often unsafe settings, making the application of traditional research designs, obtaining informed consent, and collaborating with local and international actors exceptionally difficult.(6)

Overcoming these barriers requires strategic and collaborative approaches emphasising productive partnerships between humanitarian organisations, academic institutions and local actors in health and research.(6) Empowering local research institutions boosts local sustainability, supports retention of local experts, and contributes to disaster preparedness and resilience.(6) Recommendations also include strengthening local and global humanitarian research capacity, including the development of training programmes for specialised research skills and cultural competencies as well as stressing the importance of strengthening public health information systems. Combined, these interventions enhance stability during crises and allow for more flexible and adaptive study methodologies in humanitarian research.(6)

DOMESTIC DISASTER MANAGEMENT IN AUSTRALIA

In Australia, state/territory governments and relevant local governments hold primary accountability and responsibility for the management of domestic disasters across the full disaster management cycle.(59) State and territory government responsibilities throughout the disaster management cycle include: fostering and enhancing
community resilience; performing risk assessments to drive preventative activities; ensuring compliance with national frameworks, legislation, and policies; planning for and coordinating evacuation and local disaster relief; ensuring adequate personnel and resources are available to respond to disasters; undertaking cost-effective mitigation and preparedness; and ensuring appropriate mechanisms for reviewing disaster response performance. (59) State and territory government regulations and legislation may also impart specific disaster management responsibilities on local governments in recognition of local familiarity and knowledge. In these circumstances, local governments become key participants in several responsibilities which may include promoting local resilience, conducting risk assessments and hazard risk reduction within local jurisdictions, and enhancing local preparedness and the availability of resources locally. (59)

Current disaster management arrangements also identify several stakeholders in the management of domestic disasters. These key stakeholders include individuals and families, communities, schools, emergency management volunteers, owners and operators of critical infrastructure, businesses and primary industries, local businesses, building and construction industries, insurance companies, non-government organisations (NGOs), communications and information technology industries, and scientific and research industries. (59) Importantly, engagement and active participation in the disaster management cycle is not currently mandated and thus relies on support, encouragement and incentives from local and state governments.

**Federal government engagement in responding to domestic disasters**

While the federal government operates as the leading Australian actor in response to international disasters and humanitarian crises, domestic disasters are managed under a different operational framework and structure. In relation to domestic disasters, the federal government has several responsibilities throughout the disaster management cycle. These include driving strategic disaster management plans which address areas of national priority, developing early warning and information sharing systems, promoting scientific research, and ensuring state governments have the economic and other resources required to effectively prepare for managing disasters. (59, 60) However, the federal government is not routinely an active participant in domestic disaster responses and rarely assumes lead responsibility for responding to domestic disasters, except for in certain circumstances.

The Federal Government, Department of Home Affairs (DHA), and relevant bodies have several key plans which inform a federal response to a domestic disaster. The Commonwealth Disaster Plan (COMDISPLAN) outlines how non-financial assistance can be provided by the Commonwealth Government in response to a domestic disaster. (61) Under COMDISPLAN, Australian State and Territory Governments can request assistance from the Government to support their local response to a domestic disaster, including planning, mapping, counselling, specialist advice, and physical assistance and assets. (61) In assessing the validity of a request for assistance, all available state and territory resources must either be exhausted, at significant risk of being exhausted, or cannot reach the site of the disaster in time to make a significant impact. (61) Additionally, the Federal Government must possess the capacity to make a significant impact that the relevant State Government does not; however, if Australian resources, systems, and assets cannot secure an effective and successful response to a domestic disaster, COMDISPLAN then empowers the Prime Minister and Cabinet, via DFAT, to make a request for assistance from international parties, such as in the event of a disaster-triggered humanitarian crisis in Australia. (61)

COMDISPLAN outlines relationships between Emergency Management Australia, as a subset of the Department of Home Affairs, and several key Australian partners including: (61)

- Government departments (Agriculture; Defence; Finance; DFAT; Health; Infrastructure, Transport, Regional Development and Communications; and Social Services);
• Key security actors (Australian Border Force, Australian Federal Police, Australian Maritime Safety Authority);
• Safety actors (Australian Radiation Protection Safety Agency, Australian Transport Safety Bureau, Civil Aviation Safety Authority); and
• Other Australian groups and bodies.

Importantly, COMDISPLAN provides the pathway for State and Federal Governments to request Defence Assistance to the Civil Community (DACC) from the Australian Defence Force (ADF) which can only be initiated upon the request of a relevant government.(61,62) Upon receiving a request for assistance, the Department of Defence considers the context of the domestic disaster, how urgently assistance is required, and the capacity of the ADF to make a meaningful contribution on the balance of the effect on Defence operations and requirements, threats to service outcomes, training and competency sets of ADF personnel, and overall availability of Defence resources and assets.(62) In response to domestic disasters, DACC falls under the class of emergency assistance which constitutes local emergency assistance (DACC category 1), significant emergency assistance (DACC category 2), and emergency recovery assistance (DACC category 3).(62) In accordance with relevant guidelines, healthcare provided in emergency situations by defence members does not constitute DACC but planned healthcare delivery in support of civilian health services does.(62) Additionally, the use of force by the ADF is not permitted under DACC but rather requires a request for Defence Force Aid to the Civil Authority.(62) Finally, when the ADF commits to DACC, a military command structure will be appointed and all defence personnel appointed to the response remain under the command of the ADF with military command working with relevant governments to support governments to uphold their responsibilities and obligations in relation to domestic disaster management.(62)

The National Catastrophic Disaster Plan (NATCATDISPLAN) outlines responses to a catastrophic disaster which overwhelms and completely incapacitates a State or Territory Government and all other disaster management plans and arrangements.(63) Under NATCATDISPLAN, the Australian Federal Government and other external support can only be activated upon the request of affected governments with agreement from the Prime Minister or First Minister of the region, or upon clear direction of the Prime Minister in response to a disaster eliminating the ability of the State or Territory Government to function sufficiently to request assistance.(63) While most of the assistance provided can be provided under COMDISPLAN, NATCATDISPLAN makes additional provisions and mechanisms for restoring and ensuring continuity of government in the affected region or regions.

Healthcare governance in Australia
Responsibility for funding and governing the Australian healthcare system is distributed between federal, state/territory, and local governments. Each level of government has regulatory and funding responsibilities that are likely relevant in ensuring the continuation of healthcare services during a disaster. The federal government is responsibility for funding and regulating Medicare, the Pharmaceutical Benefits Scheme (PBS), vaccinations under the National Immunisation Program, the aged care sector, Primary Health Networks to provide primary healthcare, therapeutic drugs and devices via the Therapeutic Goods Administration, the My Health Record digital platform, and providing coordination and leadership during health emergencies.(64) The relevant state or territory government is responsible for funding and managing public hospitals, preventative services, community mental health services, ambulance and emergency services, food safety regulation, and the process of licensing and monitoring health facilities.(64) Finally, local governments are responsible for environment health services (including water and waste management), food safety compliance auditing, some community and home services, and health promotion activities.(65)

Importantly, each government level retains responsibility for their assigned services or programs throughout the disaster management cycle, including health system and
service preparedness and response. Such responsibilities extend to ensuring adequate control of supply chains and access to adequate staffing and skill mixes. (66) This is an important consideration as, although health services are critical in all disasters, health services may be required to lead disaster management in certain disasters (such as heat waves, thunderstorm asthma, infectious disease outbreaks). (66) However, even when health services are not charged with leading the management of a domestic disaster, state governments remain responsible for funding, regulating, and managing: (64-66)

- Emergency services and the way in which they are utilised to manage the domestic disaster, including state ambulance, firefighting, and police services;
- Public hospitals (including emergency and inpatient services), which includes maintaining adequate and responsive surge capacity across staff (personnel with appropriate skills and experience), stuff (appropriate resources and assets), and space (appropriate physical assets and environmental considerations);
- Community mental health services (with support from the federal government in the interest of suicide prevention per existing arrangements);
- The involvement of health, and upholding health principles, in the provision of emergency shelters, relief, and evacuation centers and services.

Managing disaster health is complex because it requires governments and health systems to be proactive and adopt a risk-driven, all-hazard, and whole-of-society approach. (67) It is critical to consider the complex interactions between hazards and risks that are relevant to communities and therefore threaten community health throughout the disaster management cycle. (67) Specific activities required to undertake effective health emergency and disaster risk management include ensuring comprehensive policy and legislation, planning and coordination, securing human and financial resources, ensuring information is gathered and communicated effectively, securing health infrastructure and logistics, capitalising on community capacity, and integrated all health services and other services that support health goals. (67) These efforts are supported by comprehensive health risk assessments, understanding local capacities to support and maintain community health during disasters, and engaging in multi-sectoral preparedness. (67)

**Disaster vulnerability and hazards in Australia**

Australia relies on interconnecting systems and assets including those which provide food, water and sanitation, energy, education, health, and communication. (68) At baseline, these systems must balance competing objectives including diversity, secure supply, availability, accessibility, affordability, dependency, equity, and efficiency. (68) This is made increasingly difficult by rapid population growth, changing population demographics, rapid urbanisation, declining biodiversity and soil productivity, and shifts and strains in the global economy. (68) Other critical factors increasing the vulnerability of Australia’s systems and people include people and assets situated in hazardous regions, out-dated building and infrastructure, regulatory controls that no longer address modern hazards and threats, hazard management techniques that transfer risk (geographically, socially, temporally) rather than reduce risk, and persisting prioritisation of economic output. (68) Australia and its people are therefore vulnerable to any hazard or event that can trigger a failure with any relevant system; however, not all people and communities in Australia are equally impacted by disasters.

Australia is particularly vulnerable to natural disasters due to several complex and interacting factors, including geography, climatic features, and population distribution. (68, 69) In Australia, natural hazards are increasingly frequent and intense, services are heavily integrated and interdependent, assets and citizens are vulnerable, disaster impacts are complex and protracted, and the direct and indirect economic costs of disasters are increasing. (68) Storms, floods, and wildfires dominate Australia’s history of natural disasters accounting for 45%, 27% and 17%, respectively, of all
recorded natural disasters in Australia from 1900-2019. Importantly, the capital city of each state was established in coastal regions due to early reliance on access and import/export by shipping and thus most capital cities are vulnerable to severe storms and flooding due to coastal inundation.

Severe storms and tropical cyclones

Severe storms can cause disasters as a result of large hail, heavy rainfall, and destructive winds. Climatological and meteorological differences throughout the vast Australian landscape mean that the nature and severity of storms differ across different jurisdictions. Storms can generate high storm tides which can result in significant damages when compounded by high winds, water surges, normal astronomical tide variation, and flooding. Lightning can cause infrastructural disruption or damage during severe storms. Hail associated with severe storms can also result in significant direct and indirect structural damage. During severe thunderstorms, wind speeds can exceed 160 km/hour.

Tropical cyclones are an increasing natural hazard due to rising ocean surface temperatures which increase cyclone intensity in terms of wind speed and rainfall intensity. While increasing atmospheric temperatures may eventually come to reduce the frequency of cyclones, a higher proportion of those forming will be critically damaging. Tropical cyclones currently present a significant threat to the northern, western, and eastern regions of Australia as they develop over the warmer regions of the Coral Sea and Indian Ocean; however, with climate change there is increasing risk of cyclones affecting more southern regions of both the eastern and western coasts of Australia. Although tropical cyclones are not unique to Australia, history reveals that cyclones in the Australian region tend to behave more erratically and follow more sporadic paths than those occurring in other regions. Tropical cyclone season in Australia occurs between November and April, with most cyclones occurring between December and April.

Tropical cyclones are significant and complex hazards as they can be accompanied by severe storms that combine and contribute to flooding and landslides. Damage from tropical cyclones usually results from direct damage from high winds and flooding as a result from coastal inundation and heavy rainfall. In addition to significant environment and infrastructure damage, tropical cyclones carry a risk of human morbidity and mortality resulting from physical injury and mental distress.

Floods

Floods occur throughout Australia with varying intensity and nature due to different flood mechanisms, topographical and climatological characteristics, and patterns of human occupancy. Flooding can bring about both positive and negative impacts to the environment and communities; positive impacts include nutrient replenishment and improving soil moisture and fertility, and negative impacts include fatalities, and damage to infrastructure, economy, and the environment. Despite associated risks, floodplains are commercially, socially, and ecologically important regions for the Australian people resulting in many towns and cities located either on or near floodplains, meaning they are susceptible to flood risks.

Floods in Australia typically result from heavy rainfall and coastal inundation, and thus demonstrates sensitivity to the ongoing effects of climate change. The severity and location of flooding are determined by interactions between several factors including the volume of water, its spatial and temporal distribution, topographic characteristics, tidal variations, and usual water movements. The interaction of these factors in the Australian context usually result in flash flooding (such as from short intense rainfall) or riverine flooding (increased water volume overwhelms usual watercourses, whether natural or engineered).

Heatwaves, droughts and fires
The 2019/2020 Australian summer demonstrated the impacts of heatwaves, droughts and bushfires, each of which is worsening in severity due to climate change. Australian bushfires often result from lightning strikes or human factors, whether accidental or intentional. While grass fires and forest fires are the most common types in Australia, bushfires can occur in any fuel-laden environment including scrub and heathlands. Peak fire season across the southern third of Australia occurs between summer and autumn, the middle third between spring and early summer, and the northern third between late autumn and early spring. While notoriously complex and unpredictable, bushfire risk calculation considers weather conditions (including wind speed, humidity, and temperature), local wind effects and interaction with topography, fuel availability/load, and dryness of fuel and the environment. Many of these factors are increasing in favour of devastating fires with attribution to climate change.

Heatwaves, droughts, and fires are impacting the wellbeing and health of Australians. Across Australia, the annual number of heatwave days has been increasing since 1950, which are associated with direct (e.g. heat exhaustion) and indirect health impacts (e.g. increasing risk of cardiovascular failure, renal injury). Additionally, heatwaves are occurring more frequently, lasting longer, starting earlier in the year, and reaching higher peak temperatures. Bushfires also cause significant direct and indirect health impacts including physical injuries, mortality, mental distress and mental health injuries, and exacerbation of comorbidities (such as respiratory illnesses exacerbated by irritants and particulates).

Landslides
Landslides in Australia usually result from either intense rainfall or water leaking from infrastructure, but other triggers include earthquakes, man-made geographic disruptions or vibrations, and land undercutting. Estimating the likelihood and severity of landslides is complex due to the nature of mass land movement and the factors that can trigger, exacerbate, and mitigate landslides.

Infectious disease outbreaks
Infectious disease outbreaks are covered by AMSA Policy: Pandemics and epidemics 2020.

Australian disaster risk reduction
State and Territory Governments are responsible for ensuring building laws and regulations are adhered to and remain responsive to local hazards and risks. Australian disaster management standards reflect advocacy for engaging in quality Disaster Risk Reduction (DRR) activities. Australia has released their vision for 2030 which features all sectors making decisions informed by disaster risk, remaining accountable for DRR within the scope and capacity of the sector, and investing in disaster risk reduction. Shared and defined responsibilities, cultural change in the interest of disaster risk reduction, integrated and interconnected action, and inclusive engagement are provided as the guiding principles of Australia’s progression towards effective disaster risk reduction. An overview of the Australian disaster risk reduction framework is provided in Appendix 6.

Domestic disaster response and recovery considerations
Local and state governments are charged with ensuring they possess the capacity to provide affected communities with relief during a domestic disaster. Meaningful disaster relief may require governments to provide emergency shelter, food, water and sanitation, material aid, first aid and healthcare, emergency financial support, animal welfare, and psychosocial support.

Effective recovery from domestic disasters in Australia is guided by six nationally identified and endorsed principles. These include:

1. Understanding the local context;
2. Recognising the complex and dynamic nature of disaster recovery;
3. Using community-centered and community-led approaches;
4. Coordinating recovery activities in response to ongoing impact and needs assessments;
5. Communicating effectively with all key government, community, and other stakeholders; and
6. Recognising and building upon community and individual capacity.

Resilience
Interventions that reduce systemic and community vulnerability build system and community resilience.(75) The concept of resilience originally emerged as the potential explanation for how children achieved unimpeded development despite facing significant adversity during early childhood.(76,77) Resilience has come to represent the ability of a system to overcome or eliminate stress through either direct opposition, mitigation of stress, or complex modulation.(76) It has been suggested that there are four specific components or elements of resilience: strength, flexibility, adaptability, and responsiveness.(78) Disasters trigger a complex web of complex stressors, emotions, and challenges against which resilience can be seen as a protective factor, including for mental health.(79,80)

Despite being regarded as a significant protective factor, often representing the goal of disaster preparedness in Australia, resilience is not without significant weaknesses and limitations. Firstly, resilience alone is not sufficient to maintain health and wellbeing.(81) Secondly, resilience is often portrayed as the ability to resist or be unaffected by stressors, which is simply not feasible in the context of disasters.(82) Thirdly, discussions of resilience at high levels (such as organisational, governmental, or community levels) can result in the phenomenon of responsibilisation.(82,83) Responsibilisation is a process by which demanding that communities or systems be resilient comes to demand that individuals remain unaffected by disasters, indirectly excusing communities or systems from addressing vulnerabilities.(82,83) The inevitable challenges and unrealistic expectations associated with demanding that individuals remain unaffected by disasters can compound trauma as well as triggering the emergence and worsening of mental illnesses.(80,82,83) This means that calls for communities and individuals to ‘keep on being resilient’ and comments asserting ‘Australian’s are resilient people’ do not encourage a positive response to disasters but can prove to be both directly and indirectly harmful. It is therefore critical that the concept of resilience must be protected from holding individuals accountable for response and recovery, but hold communities accountable for promoting the empowerment and inclusion of individuals to support individual resilience without relying on it.(82)

Collective trauma and disaster recovery
Many people will experience intense stress reactions following a disaster, most of which are normal rather than pathological, of whom most return to healthy function without professional interventions.(84) However, there is a proportion who suffer significant psychological distress which may progress to formal mental health disorders such as post-traumatic stress disorders, anxiety, depression, substance dependence and abuse disorders, somatic ill-health, and sleep disturbances.(84) Certain groups in communities are more vulnerable and prone to complicated grief and trauma reactions, including women, children, marginalised groups, those with poor social support networks, and those with previous mental health conditions.(84) Therefore, although not everyone exposed to a disaster or trauma will manifest formal mental health disorders, it is critical that mental health care is embedded and addressed throughout the disaster management cycle.(84)

Managing the collective trauma that can result from disasters requires a structured and evidence-informed approach, commencing long before the disaster impact. Prior to a disaster that may cause collective trauma, several activities should be undertaken to enhance the community response to a disaster.(85) Such activities include early engagement between emergency management and community stakeholders which
result in the development of business and support service continuity plans. (85) Community leaders should prepare and ensure capability to provide communication during disasters and potential collective trauma events. (85) Additionally, community services should be prepared to deliver services that are sensitive to the specific needs of communities across a broad geographic distribution, supported by ensuring community members and stakeholders are trained to provide physical and psychological first aid. (85)

During an event or disaster, it is critical that communication channels promote the principles of psychological first aid, social cohesion, and responsive use of social media, all tailored according to the specific needs of the community. (84, 85) Key stakeholders should be involved in the delivery of psychological first aid and diverse, but targeted, support services to those who are affected by the collective trauma event. (85) Importantly, evidence outlines that early psychological debriefing is not beneficial in the long-term and may even be harmful; therefore, psychological first aid should be provided rather than psychological debriefing. (84, 85) Following a disaster, it is critical that all stakeholders (including health services and community-based clinicians) understand their role in community recovery and are supported with long-term information and advice. (85) In terms of long-term recovery, communication should validate the long-term impacts of collective trauma and remind communities of the services and resources available. (85) Finally, a critical consideration throughout the spectrum of a response to a domestic disaster and collective trauma event is the management of mortuary affairs, funerals, memorials, and coronial processes that result from disasters. (85)

Domestic frontline responder and volunteer wellbeing

It is recognised that a spectrum of mental health problems can emerge following a traumatic event, such as a disaster, which include depression, anxiety, post-traumatic stress disorder, acute stress disorder, adjustment disorder, somatic complaints, and substance misuse. (86) Although these mental health problems are significant in the community following a disaster, first responders are known to be at high risk due to repeated exposure to sources of trauma, often compounded by attempts to minimise symptom manifestation to appease work cultures, the emergence of substance abuse, personal conflict, and potential physical violence. (86, 87) There is also growing acceptance of the impact of moral injury on psychological well being, of which there are three types: (88) (1) moral pollution, resulting from witnessing catastrophic scenes and human suffering; (2) moral betrayal, resulting from systemic failures or injustices; and (3) moral compromise, resulting from conflict between personal values and actions or inactions due to constraints of the role. Critically, mental health disturbances and disorders not only threaten individual wellbeing among first responders, but also the continued availability of a first responder workforce to render necessary assistance in response to future disasters. (88, 89)

PTSD has been identified in 8% of active firefighters and 16% in retired firefighters. (86) Among Australian paramedics, research has identified PTSD in 11%, depression in 15%, anxiety in 15%, and general distress in 27% of active paramedic and ambulance personnel. (86) Additionally, first line responders have a higher rates of suicidal ideation and attempting to die by suicide than the general population, which appears to be sensitive to working as a paramedic or in the capacity of a healthcare first responder. (87) This is proposed to be the result of repeated exposure to trauma which progressively contributes to the development of formal mental health disorders. (86) However, it is also believed that other factors compound these repeated trauma exposures, including occupational uncertainty, atypical working hours, imbalances in effort-reward, lacking procedural justice, workplace conflicts, lacking occupational social support, and stigma. (86, 87)

Interestingly, it has been found that compulsory debriefing should be ceased as increased risk of PTSD has been identified among those who participate in mandatory debriefing, suggesting forced debrief may interrupt normal coping mechanisms. (86)
Finally, three significant factors that impact the willingness and ability of first responders to seek appropriate support for mental health problems include:(86,87) (1) stigma; (2) a lack of insight or awareness of their need for help; and, (3) those with management responsibilities lacking awareness of how to recognise and action a request for assistance. Another significant difficulty is that first line responders must often come to rely on contacting 000 for support in a crisis, and thus they must rely on their own coworkers.(89)

As early as first responder recruitment, recruits should be briefed on the challenges and mental health threats inherent in their desired role.(88) Current recommendations include that all first responders undertake mental health awareness training, including support in generating safety plans and accessing available services.(88,89) This can be supported by calls that the Commonwealth Government should establish and maintain a national register of health professionals who possess the skills to assess and address the specific mental health needs and threats experienced by first responders.(89) Such skills should include: understanding and recognising how occupational factors and pressures faced by first responders may alter the emergence and presentation of mental health disorders; awareness of occupational requirements and what would constitute a relevant functional assessment; the ability to establish meaningful and appropriate goals for treatment; and, either the appropriate competence to deliver evidence-based treatment or the ability and willingness to make necessary referrals to provide first responders with access to evidence-based treatments.(90)

There are several organisational interventions that should be implemented by first responder organisations, including regular scheduled ‘down time’, ensuring managers are appropriately trained to detect and respond to wellbeing threats, ensure clear protocols for sensitive and appropriate management of staff requiring assistance, and engaging workers in industry-wide support and advocacy services.(88) There are also formal recommendations that mental health services for first responders be extended to all volunteers who work in a first responder capacity and anyone who has ever worked in such a capacity regardless of leaving their organisation or retiring.(87,89) Additionally, a recent review identified that there is no rigorous research into the impact of these events and experiences on the families of first responders;(91) however, it is considered in the best interest of first responders and their families that families receive education and support surrounding risks, symptoms, and interventions related to trauma-related stress and the potential emergence of formal mental health disorders.(88)

References

5. Below R, Wirtz A, Guha-Sapir D. Disaster category classification and peril terminology for operational purposes. [Internet]. Louvain-la-Neuve, Belgium:


45. International Committee of the Red Cross. International Humanitarian Law and the Challenges of Contemporary Armed Conflicts [Internet]. Geneva,


Appendices

APPENDIX 1: KEY DEFINITIONS

1. **Disaster**: A serious disruption of the functioning of a community or a society causing widespread human, material, economic and environmental losses which exceed the ability of the affected community/society to cope using its own resources

2. **Humanitarian crisis**: A situation where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single and/or ongoing UN country program

3. **One Health**: A collaborative, multisectoral, and transdisciplinary approach—working at the local, regional, national, and global levels—with the goal of achieving optimal health outcomes recognizing the interconnection between people, animals, plants, and their shared environment

4. **Disaster prevention**: Regulatory and physical measures to ensure that emergencies are prevented, or their effects mitigated and mitigation is defined as measures taken in advance of a disaster aimed at decreasing or eliminating its impact on society and environment

5. **Disaster response**: Wide array of endogenous and exogenous reactions, measures and policies that are aimed at mitigating, counteracting and preventing disaster impacts and effects

6. **Disaster recovery**: The process of restoring and improving services, living conditions, and infrastructure affected by disasters

7. **Vulnerability**: The extent to which a community, structure, services or geographic area is likely to be damaged or disrupted by the impact of a particular hazard, on account of their nature, construction and proximity to hazardous terrains or a disaster prone area

8. **Risk**: Measure of the expected losses due to a hazard event occurring in a given area over a specific time period

9. **Hazard**: A dangerous condition or event, that threat or have the potential for causing injury to life or damage to property or the environment

APPENDIX 2: CODE OF CONDUCT, SPHERE STANDARDS & SENDAI FRAMEWORK

**Code of Conduct**
The Code of Conduct for International Red Cross and Red Crescent Movement and NGOs in Disaster Response Programmes is a series of 10 principles that seek to ensure a certain standard of behaviour. These ten principles are:(36)

1. The humanitarian imperative comes first
2. Aid is given regardless of the race, creed or nationality of the recipients and without adverse distinction of any kind. Aid priorities are calculated on the basis of need alone
3. Aid will not be used to further a particular political or religious standpoint
4. We shall endeavour not to act as instruments of government foreign policy
5. We shall respect culture and custom
6. We shall attempt to build disaster response on local capacities
7. Ways shall be found to involve programme beneficiaries in the management of relief aid
8. Relief aid must strive to reduce future vulnerabilities to disaster as well as meeting basic needs
9. We hold ourselves accountable to both those we seek to assist and those from whom we accept resources
10. In our information, publicity and advertising activities, we shall recognise disaster victims as dignified human beings, not hopeless objects

**Sphere Handbook**
The Sphere Handbook is a manual on international humanitarian operations that includes an extensive section on healthcare standards and ethical practices.

The first set of standards are the Protection Principles which outlines the role and responsibilities humanitarian actors play in protecting people, keeping them safe, providing access to assistance and to support recovery from violence. There are four main principles:
1. Enhance people’s safety, dignity and rights and avoid exposing them to further harm
2. Ensure people’s access to impartial assistance, according to need and without discrimination
3. Assist people to recover from the physical and psychological effects of threatened or actual violence, coercion or deliberate deprivation
4. Help people to claim their rights

The second set of standards are the Core Humanitarian Standards which aim to improve the quality and effectiveness of a humanitarian response, as well as improve accountability. These standards are:(27)
1. Humanitarian response is appropriate and relevant
2. Humanitarian response is effective and timely
3. Humanitarian response strengthens local capacities and avoids negative effects
4. Humanitarian response is based on communication, participation and feedback
5. Complaints are welcomed and addressed
6. Humanitarian actors continuously learn and improve
7. Staff are supported to do their job effectively, and are treated fairly and equitable
8. Resources are managed and used responsibly for their intended purpose

The Sphere Handbook contains extensive sections outlining the Minimum Standards that should be achieved during a humanitarian response. These standards can be subdivided into 4 domains which each have a series of criteria that should be achieved to ensure the needs of the community are holistically met. These four domains are:(27)
1. Water supply, sanitation and hygiene promotion
2. Food security and nutrition
3. Shelter and settlement
4. Health

**Sendai Framework**
The Sendai Framework of Disaster Risk Reduction is a document used globally as a reference for many disaster management policies. The framework focuses on 4 priorities which are:
1. Understanding disaster risk
2. Strengthening disaster risk governance to manage disaster risk
3. Investing in disaster risk reduction for resilience
4. Enhancing disaster preparedness for effective response and to ‘Build Back Better’ in recovery, rehabilitation and reconstruction
Through countries internationally focusing on these 4 priorities, it is hoped that 7 global targets can be reached as indicators of progress. These 7 global targets are:

1. Substantially reduce global disaster mortality by 2030, aiming to lower the average per 100,000 global mortality rate in the decade 2020–2030 compared to the period 2005–2015;
2. Substantially reduce the number of affected people globally by 2030, aiming to lower the average global figure per 100,000 in the decade 2020–2030 compared to the period 2005–2015;
3. Reduce direct disaster economic loss in relation to global gross domestic product (GDP) by 2030;
4. Substantially reduce disaster damage to critical infrastructure and disruption of basic services, among them health and educational facilities, including through developing their resilience by 2030;
5. Substantially increase the number of countries with national and local disaster risk reduction strategies by 2020;
6. Substantially enhance international cooperation to developing countries through adequate and sustainable support to complement their national actions for implementation of the present Framework by 2030;
7. Substantially increase the availability of and access to multi-hazard early warning systems and disaster risk information and assessments to people by 2030.

APPENDIX 3: INTERNATIONAL HUMANITARIAN LAW

Summary of International Humanitarian Law (IHL).
There are four distinct themes that guide IHL implementation:(38)
1. Within an armed conflict zone, combatants and non-camabats are present
2. Combatants are military persons who are deemed legitimate tarfetsunless hors de combat
3. Civilians are non-combatants and are protected by IHL only if they are not actively involved in the hostility of war
4. Other persons in the armed conflict zone are protected under IHL if not involved in the hostilities of war and be be identified by the use of special symbols

Functions of the International Committee of the Red Cross
The International Committee of the Red Cross (ICRC) holds a key position and role in relation to IHL. In overseeing the development, deployment, adherence and protection of IHL, the ICRC serves several significant functions including:(39)
1. Monitoring: continuous reappraisal of humanitarian laws to adjust to the changes of conflict to prepare states to adapt
2. Catalyst: ensuring discussions between governments and other interest groups for cohesive action to resolve problems encountered including amendments to International Humanitarian Law
3. Promotion: advocacy and education for IHL implementation, education, and practice
4. Guardian Angel: ensure that IHL is not subject to legal changes that impairs the protection of persons that are not involved in the hostilities of conflict
5. Direction Action: when IHL is instigated in armed conflict, contributing to its application
6. Watchdog: ensures that when serious violations of IHL occur, the States and parties involved in this armed conflict as well as the international community are made aware
Comparison of the types of conflict and the laws that govern them

<table>
<thead>
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<th></th>
<th>Armed Conflicts (IHL)</th>
<th>Situations other than armed conflicts (IHRL and domestic law)</th>
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</table>
| Medical personnel   | 1. Protection and respect – medical personnel must be protected and respected while performing their humanitarian function; if a humanitarian worker loses their protection, the wounded and sick under their care remain protected  
2. Care provision – passage of medical personal and services must not be interred with  
3. Personnel cannot be punished for providing impartial care  
4. Ethical duties protected by International Humanitarian Law | 1. Protection and respect – right to security and protection against deprivation of life for both the medical personnel and the wounded and sick  
2. Care provision – the right to health governs the prevention of interference with treating the wounded or sick, including arresting medical personnel for providing of care, even if National Law allows for it to occur  
3. Performing ethical duties should not result in the punishment of medical personnel or contravene their delivery of care |
| Medical units and transports | 1. Units and transportation must be respected and protected under IHL  
2. Distinctive emblem – the red cross emblem is protected under IHL, and identifies that the unit, building, vehicle or personnel carrying it are entitled to protections under IHL with breaches representing a war crime  
3. Misuse of the emblem – given its importance in identifying those entitled to protection under IHL, the improper use of the emblem (perfidious use, to falsely protect or hide combatants, improper use resulting in death or injury) is a war crime | 1. The right to health outlines the obligation to ensure uninterrupted access to health infrastructure (including transports and critical health units) and means that health infrastructure cannot be impeded for the purpose of law enforcement |
| Wounded and Sick    | 1. Attacking, harming or kill – the wounded and sick must be always protected; denial of treatment constitutes cruel, inhuman, degrading and, potentially, tortuous treatment  
2. Searching for and collecting – in armed conflicts, parties must make all efforts to | 1. Attacking, harming, or killing – IHRL protects the wounded and sick from attacks and have the right to personal security; denial of treatment constitutes cruel, inhuman, degrading and, potentially, tortuous treatment  
2. States must ensure the right of access to health facilities, goods and services and |
collect wounded and sick without delay
3. Protection and care – all parties must ensure access to care and protect the wounded and sick
4. Treatment without discrimination – treatment decisions are to be made on the basis of clinical need alone

provide access when individuals cannot access it themselves
3. Treatment without discrimination – falls under the right to health for individuals

IHL: International Humanitarian Law
IHRL: International Human Rights Law

APPENDIX 4: FRAMEWORKS FOR HUMANITARIAN ACTION AND AID BY AUSTRALIA

Australia’s foreign aid and humanitarian funding
The overall purpose and role of Australia’s aid and humanitarian action is the promotion of Australia’s interests. (12,13) According to the Australian Government and the Department of Foreign Affairs and Trade (DFAT), from the 2014-2015 financial year onward, at least 90% of outgoing foreign aid will be directed to the Indo-Pacific region as a geographically and strategically critical region for Australia. (13) A core assertion of this policy is that economic growth occurs when private industries are supported and grow, and therefore funding reportedly targets private industries in partner countries. (13) Key investments prioritised by Australian aid and funding commitments, according to its policy, include: (13)
1. Supporting infrastructure development and facilitating trade agreements
2. Developing agriculture, fisheries and water infrastructure and industry
3. Supporting effective governance over policies, organisations, institutions, and economy
4. Investing in and supporting education and health
5. Building resilience through the effective use of humanitarian assistance, disaster risk reduction, and social protection
6. Enhancing gender equality and the empowerment of women and girls

Australia’s humanitarian aid program is assessed across three levels: the strategic level (which includes assessment against 10 targets), the country/regional/partner level (which includes investment benchmarks), and the project level (including input and output audits). (14) The strategic targets provided in the framework include: (14)
1. Promoting prosperity and economic development through increased aid-for-trade funding
2. Engaging the private sector
3. Reducing poverty by using Aid Investment Plans to invest in pathways out of poverty
4. Empowering women and girls
5. Focusing on the Indo-Pacific region
6. Delivering on commitments and evolving from standard and traditional donor-recipient relationships
7. Working with effective partners
8. Ensuring value-for-money
9. Increasing consolidation in terms of the number of individual transactions and isolated financial investments
10. Combating corruption

If, at the project level, funding and aid investments fail to demonstrate adequate performance, they become subject to significantly tighter regulation with failure to
demonstrate a substantial improvement in output within one year of notice warranting project and funding cancellation.(14)

Humanitarian action undertaken by Australia

Humanitarian action led or undertaken by the Australian Government is led by the DFAT. In outlining Australia’s strategy and approach to humanitarian action, DFAT provides four key objectives in the Department of Foreign Affairs and Trade Humanitarian Strategy:(12)

1. Strengthen international humanitarian
   1. Contributing to reformation of international humanitarian systems in a manner that reflects Australia’s priorities
   2. Undertaking humanitarian action that is principle-based, accountable, and contributing to the protection of the vulnerable
   3. Strengthening the direct and indirect links between humanitarian action and support for development (noting how this may differ given the evolving and changing nature of protracted crises)

2. Disaster risk reduction
   1. Supporting countries in the Indo-Pacific region to uphold commitments to the Sendai Framework for Disaster Risk Reduction 2015-2030
   2. Ensuring aid and humanitarian investments are informed by risk
   3. Upholding the implications for aid and humanitarian action arising due to adoption of the Paris Climate Change Agreement

3. Support preparedness and response, particularly within the strategically important Indo-Pacific region
   1. Supporting partners to prepare and respond to crises effectively
   2. Supporting and delivering, where require, effective responses to disasters, particularly in the Indo-Pacific region
   3. Protecting and assisting populations that are affected and displaced by conflict or humanitarian crises
   4. Building resilience among those experiencing, or at risk of experiencing, slow-onset or protracted crises

4. Enable early recovery
   1. Enabling and supporting rapid recovery from disasters and crises
   2. Supporting and promoting recovery efforts that integrate the “build back better” principle
   3. Ensuring affected governments and populations have timely access to the appropriate technical skill sets and the assistance required for recovery

When planning and undertaking humanitarian action, the Australian Government and DFAT consider several important factors. While not all encompassing, the primary considerations can be grouped according to the following:(12)

1. Necessity of humanitarian action, which is informed by:
   1. The impact of the disaster or crisis and the resulting needs of the affected population;
   2. The capacity of the relevant government to facilitate an effective response;
   3. The receipt of a formal request for assistance to the Australian Government; and
   4. The presence of humanitarian partners already active in the affected region and their capacity to support an effective response.

2. Australia’s context, which is informed by:
   1. Australia’s national interest, including strategic interests and the threat to regional stability;
   2. Australia’s capacity to contribute to an effective humanitarian response; and
   3. Australia’s experience, values, and partnerships that may support an effective contribution to the humanitarian response.
3. Economic position, which is informed by:
   1. Funding sources available to support humanitarian action;
   2. The adequacy of economic support for humanitarian action; and
   3. The degree to which funding and economic support uphold effective financial governance standards and commitments to donor partnerships

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**APPENDIX 5: COMPARISON OF FEDERAL GOVERNMENT ENGAGEMENT IN INTERNATIONAL AND DOMESTIC DISASTER RESPONSE**

<table>
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<tr>
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<th>Domestic Disasters</th>
<th>International Disasters and Humanitarian Crises</th>
</tr>
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<tbody>
<tr>
<td><strong>Response Lead</strong></td>
<td>State or Territory Government maintains responsibility and command/control of the disaster.</td>
<td>Foreign government maintains responsibility and command/control of the disaster or humanitarian crisis.</td>
</tr>
</tbody>
</table>
| **Government Engagement** | 1. State and Territory Governments maintain primary responsibility for domestic disaster management.  
   2. Federal government engagement occurs only upon a request for assistance by State or Territory representatives, but States maintain responsibility and control of response (under COMDISPLAN). Under such a request for assistance, other State Governments may become engaged but the requesting Government maintains responsibility over disaster management.  
   3. Federal government only leads the response to restore continuation of government upon which the State Government regains command and control (under NATCATDISPLAN). | Australian Federal Government receives request from foreign government and aids the foreign government by coordinating Australia’s response. Requests may be made to State or Territory Governments for specific resources, but Federal Government maintains oversight and control. |
| **Federal Government Engagement Trigger** | Requires request for assistance from State or Territory Government (COMDISPLAN), or complete destruction and discontinuation of State or Territory Government (NATCATDISPLAN), in response to a disaster which overwhelms the capacity of the relevant government to manage the disaster. | Requires request for assistance from the affected international government in response to a disaster which overwhelms the capacity of the relevant government to manage the disaster. |
| **Department**       | Department of Home Affairs                                                           | Department of Foreign Affairs and Trade       |
Disaster Response Partners

| Disaster Response Partners | COMDISPLAN: Airservices Australia; the Attorney-General’s Department; Australian Border Force; Australian Maritime Safety Authority; Australia Radiation Protection Safety Agency; Australian Transport Safety Bureau; Civil Aviation Safety Authority; Department of Agriculture; Department of Finance; Department of Foreign Affairs and Trade; Department of Health; Department of Infrastructure, Transport, Regional Development and Communications; Department of Social Services; Geosciences Australia; and Services Australia. | DFAT’s Humanitarian Strategy: DFAT Crisis Response Team; Australian Civilian Corps; State and Territory Governments; Australian Red Cross Humanitarian Action; Non-Government Organisations; and United Nations |

Common to both responses: Australian Federal Police; Australian Defence Force

APPENDIX 6: Australian disaster risk reduction framework summary

The first national priority is understanding disaster risk. By 2023, it is expected that relevant stakeholders and decision-makers will be legally liable for DRR within their jurisdiction, and that Australia will have enhanced risk information sharing capabilities (National Resilience Taskforce, 2018a). To achieve this priority, seven strategies have been nominated (National Resilience Taskforce, 2018a):

1. Improving public awareness and engagement in disaster risk management;
2. Identifying resource gaps, including those related to data and information;
3. Address barriers to effective and meaningful data sharing;
4. Expand current perceptions and understanding of disaster risk to include emerging and other potential future threats;
5. Develop disaster risk communication and information sharing systems;
6. Support longitudinal research to drive innovation, knowledge, and disaster education; and,
7. Improve stakeholder awareness of disaster risk by means of improved disclosure.

The second national priority is decision-making accountability. By 2023, it is expected that disaster risk will be considered and managed by relevant stakeholders alongside other risks, decisions are made based on effectiveness and cost-benefit analysis, priority disaster risks are identified and actively managed, and frameworks are developed and applied across all environments (National Resilience Taskforce, 2018a). To achieve this priority, six strategies have been nominated (National Resilience Taskforce, 2018a):

1. Consider the balance of potential benefits and opportunity costs in all DRR decisions;
2. Identify disaster risks of the highest priority, in addition to how best to mitigate them;
3. Build decision-making capacity to address DRR in policy and investments;
4. Establish incentives and reduce barriers to reduce disaster risk;
5. Maintain planning and development to achieve rapid change (including societal, economic, environmental, and cultural change); and,
6. Promote and encourage compliance with resilience requirements through inclusion in relevant policies, codes, and legislation.
The third national priority is enhanced investment in DRR. By 2023, it is expected that DRR investments address local and national disaster risks, investments are designed to bring about diverse and maximal outcomes, and investments are effective and reduce disaster recovery costs. To achieve this priority, six strategies have been nominated (National Resilience Taskforce, 2018a):

1. Pursue opportunities for collaborative commercial funding of DRR;
2. Develop investment tools to guide and inform economic investments;
3. Leverage current and future government funding sources for DRR;
4. Identify novel and additional potential sources of economic support;
5. Improve insurance accessibility, variety, and uptake; and,
6. Work to empower communities and other stakeholders to make informed investments in Disaster Risk Reduction.

The fourth, and final, national priority is effective governance, ownership, and responsibility. By 2023, it is expected that all stakeholders understand their responsibilities, there is effective risk identification and reduction across sectors, DRR responsibility exchanges are transparent and acknowledged, and all sectors and communities engage in national approaches to DRR. To achieve this priority, six strategies have been nominated (National Resilience Taskforce, 2018a):

1. Establish national oversight of, and guidance for, DRR;
2. Establish national plans to implement relevant DRR frameworks;
3. Support locally-led and locally-appropriate DRR interventions;
4. Develop incentives for transparent DRR interventions;
5. Ensure regular and quality DRR reporting; and,
6. Create and promote governance pathways for use in DRR projects.

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Category: G – Global Health
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Jainam Shah, Zachary Horn, Aatif Syed, Alexandra Wilson, Guy Jeffery, Jasmin Somers, Sophie Moore, Ashraf Docrat (Policy Mentor), Sally Bardman (Global Health Policy Officer)

Healthcare in Conflict Zones
Reviewed and Adopted, Council 2, 2017
T Tan, A Keen, V Pillutla, C Lee, A Rottler, P Walker
Adopted, Council 2, 2015

Disaster and Emergency Medicine
Adopted at Council 3, 2019
Helena Qian, Caitlin Cusack, Guy Jeffrey, Sashika Harasgama, Unni Susil Kumar, Akhilesh Ayalasomayajula, Lorane Gaborit, Patrick Song, Travis Lines (Global Health Policy Officer)