REFERENCE

FIRST-AID TRAINING PROGRAMME: AN OVERVIEW

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PREFACE

First aid on the battlefield was one of the first services provided by the International Committee of the Red Cross (ICRC). Furthermore, the International Red Cross and Red Crescent Movement (Movement) has, since its inception, been mainly associated with the delivery of first aid. Provision of an immediate response to the consequences of wars, disasters and epidemics, by first-aiders and local communities, was a concept pioneered by the Movement. More than 150 years later, first aid is now a core activity of many National Red Cross and Red Crescent Societies (National Societies). The ICRC, in accordance with its mandate, remains the chief advocate and the main international actor with regard to the provision of trauma first aid in armed conflict and other situations of violence; the International Federation of Red Cross and Red Crescent Societies (IFRC), and the National Societies, usually take a broader approach to first aid. All Movement actors are involved in or support the development of first-aid guidelines on a local, national, regional, and even an international, basis. No guideline fits all contexts; and to apply international guidelines indiscriminately – without regard to differences in custom and culture – is to ignore reality and the needs that exist. It is widely acknowledged – and now the subject of a great deal of discussion – that first-aid guidelines and activities must be more context-specific. There is general agreement that two issues deserve particularly close attention.

The first concerns the need for clear **guidelines for first-aid programmes and for first-aid frameworks that enable the delivery of trauma first aid and basic emergency care in conflict-affected settings**. Standardized first-aid guidelines and handbooks – international and even national – often do not take into account or address contexts affected by conflict or other violence. As a result, implementing these guidelines in such contexts may simply not be possible. In the past three years, the ICRC's Health Unit and the ICRC's first aid and pre-hospital emergency care programme have developed first-aid guidelines and frameworks that are adapted specifically for use in settings affected by conflict or other violence, and for use by those who typically work in such settings.

Second, **first-aid programmes and guidelines should be designed to fit the specific context in which they are to be implemented and the actors concerned**. ICRC first-aid delegates and other ICRC personnel working in the area of first aid must assess and understand both current conflict-specific needs (blast injuries, gunshot wounds, burns, massive haemorrhage, etc.) and the pre-existing needs, diseases, constraints and health inequities in the context in which they are operating. Understanding conflict-specific needs and the socio-cultural context is crucial for designing efficient and effective first-aid programmes or emergency-care response systems for specific actors. Inadequate contextualization (context and actor) can result in improper or erroneous priorities being set for health services; it can also have damaging consequences for emergency-care systems and social dynamics.

ICRC first-aid personnel also need to assess and understand existing structures, services or local methods of response. Experience has shown that we can often assume the existence of some level of functioning basic health infrastructure that we can connect to, build on or support. It is essential for every first-aid programme to continually evaluate the services available, as the contexts in question are usually in a state of flux. In most conflict-affected contexts, official health services break down shortly after the onset of the conflict; and community-based (informal) health services, which often supplement or even fully replace official health-care services, are frequently disrupted by the fighting.

In general, standardized international approaches to first aid are not sufficiently flexible or adaptable. They are largely Western or Westernized; and even the needs assessments conducted within these frameworks tend to be one-off snapshots that do not take local circumstances into account. The ICRC continues to grapple with the challenge of providing adequate and appropriate, and hence context-specific, emergency care for conflict-affected populations: for instance, it pushes for more localized efforts. Localization has become something of a buzzword: it is even included in the new ICRC institutional strategy – but it has many dimensions and is interpreted in many different ways. The concept originated in the recognition that there are local capacities that can be tapped into and built on; that local actors, especially the National Societies, are there before, during, and after an armed conflict; and that these actors understand the context and culture in question. Localized action is therefore potentially capable of responding more effectively to the needs of people affected, assisting in the implementation of services, and strengthening the resilience of people affected.

Please note that these guidelines for first-aid training programmes have been developed primarily for ICRC red-line managers, ICRC coordinators (health, cooperation, protection, etc.), ICRC health-programme managers and/or other ICRC personnel working in the area of first aid – to help them reach a fuller understanding of the ICRC's first-aid training programmes. Therefore, the guidelines do not contain specific clinical guidance for first aid. Please contact your first-aid delegates or the first-aid coordination team for technical or clinical guidance.

Thomas Wilp
Pre-hospital Emergency Care and First-Aid Coordinator
International Committee of the Red Cross

ABBREVIATIONS

EMS	Emergency medical services
EMT	Emergency medical technicians
HCiD	Health Care in Danger
ICRC	International Committee of the Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
IHL	International humanitarian law
IT	Information technology
MHPSS	Mental-health and psychosocial support
NGO(s)	Non-governmental organization(s)
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PAHO	Pan American Health Organization
PHEC	Pre-Hospital Emergency Care
RBM	Results-based management
ToR	Terms of reference
UN	United Nations
UNDSS	United Nations Department of Safety and Security
WHO	World Health Organization

1. GENERAL INTRODUCTION

The following overview of the ICRC's first-aid training programme summarizes years of first-aid-related planning, implementation and field observation – operational and/or educational – in various circumstances and contexts, especially in sensitive and insecure contexts[1] or those with limited resources (fragile/austere environments). The first-aid training programme is a flexible and adaptable programme consisting of several different elements. Basic first-aid training for first aiders and emergency-care responders is one of the most common activities undertaken by the ICRC. It equips the personnel concerned with the skills and knowledge necessary to respond effectively during times of crisis. The ICRC first-aid programme may also offer other services that are not always regarded as part of its brief: for instance, working with legal officials to develop a legal framework – the so-called "Good Samaritan law" – that provides legal protection for people delivering first aid to the wounded and the sick; the protection is intended to reassure first-aiders who may be hesitant to provide help because they are afraid of being sued or prosecuted for causing unintentional injury or wrongful death. This first-aid training programme overview aims to provide a practical overview of what, how and where first-aid training programmes can be offered by the ICRC.

This document provides an overview **only of the ICRC first-aid training activities**. Separate operational guidelines for first aid are available for first-aid delegates and other ICRC personnel working in the area of first aid; and a separate overview of the ICRC's Pre-Hospital Emergency Care programme (PHEC) and its activities will be available in 2021.

1 The term 'sensitive and insecure contexts' covers a broad range of circumstances, including the following: situations that involve no violence but that nonetheless present emergency-care responders with perception or acceptance issues; violent demonstrations, riots or spontaneous acts of rebellion (also referred to as 'internal disturbances' or 'internal tensions'); armed conflict; and many other situations characterized by various kinds of disorder. In addition, natural disasters, and situations where banditry, gang violence or other forms of criminality are pervasive, can give rise to security and access issues.

To ensure a coherent and multidisciplinary approach, the following ICRC reference frameworks should also be consulted:

- reference frameworks for other health-care sub-programmes (Assistance Medical, Assistance Orthopaedics; Water and Habitat – continuity of patient care): first level of health care; hospital care; physical rehabilitation programmes; mental-health and psychosocial support (MHPSS); health care in detention
- reference framework for forensic services
- reference framework for weapon contamination and the civilian population
- reference framework for cooperation (National Society/Movement – partnering and capacity building)
- reference framework for protecting the civilian population and the wounded and the sick
- reference framework for protecting the civilian population (displaced people)
- Prevention reference framework – key area: acceptance for the ICRC.

2. THE ICRC FIRST-AID PROGRAMME: WHAT WE DO

2.1 PROVISION OF FIRST AID

The overall **goal** of the ICRC's first-aid programme is to ensure that during emergencies (wars, conflict and/or violence), wounded and acutely sick people benefit from humane, impartial, effective and secure provision of first aid. This care should be provided by confident, skilled and properly supported emergency-care responders abiding by humanitarian values and principles. Sometimes, casualties may have to be evacuated for definitive care. It must be kept in mind that the ICRC's first-aid programme rarely sends in ICRC personnel – doctors, nurses, paramedics, etc. – to provide direct help to victims of armed conflict or other situations of violence. It is equally important to note that the ICRC's first-aid programme most often seeks to **empower** individual **local** first-aiders.

To achieve the overall goal of providing first aid, the following issues must always be kept in mind:

- The ICRC is mandated to operate in situations of armed conflict and other violence. **These situations reveal the true degree of acceptance and effectiveness achieved by the emergency-care responders and the organization they represent**. Acceptance and effectiveness are dependent on the daily attitudes and work of the responders and their organization.
- Effective management of risks and security depends on many different factors: it should result in every wounded or acutely sick person, and every emergency-care responder, getting the respect and support they need.
- Building first-aid capacities will enable **people to "make a difference": the added or distinctive value that "Red" support**[2] can provide will enable them to do so in a way that is stronger, bigger, better and more durable. It is hoped that this distinctiveness will be repaid through increased respect, value and appreciation from the community, patients and their families.

The general ICRC **approach** to first aid activities during emergencies and for first aid empowerment has three elements: people, context, and needs and results.

2 "Red" support refers to the specific kinds of assistance provided by the Movement.

People	- Experiences related to emergencies - Desire for involvement and level of confidence in responding to emergencies - Practices, knowledge and perceptions related to emergencies, and to preventing them - Practices, beliefs, and knowledge of the religious and cultural context with regard to preventing and responding to emergencies
Context	- Security - Resources available - Community resilience - Emergency-response system (who does what, where, when, and how) - Access to and performance of the people/facilities to whom or to which emergency cases are referred for further care
Needs and results	**Needs**: - Who is injured or acutely sick? How, when, where? - Nature, cause, and number of emergency situations and cases - Consequences of emergencies - Support for emergency preparedness and response **Results** (care and humanitarian outcomes): - Immediate care; referral for further care; recovery - Social fabric: the relationships and connections between first aid responders and the community - Humanitarian assistance (access to casualties, access to health care)

2.2 RESPONDING TO CONTEXT-SPECIFIC NEEDS

All PHEC services (from basic first aid to professional ambulance care) ***must*** be context-specific. This ensures that every priority need is addressed adequately and appropriately; and it requires our first-aid programmes in conflict-affected settings to be sufficiently flexible. Basic, simple and realistic first responses must be developed – or where they still exist, strengthened – to ensure the meaningful participation of local actors in the development and implementation of such responses. The final objective is to ensure that these local actors are willing and able to fully take over an first-aid response. To that end, our local counterparts should be permitted or enabled to influence and shape the first- aid response system – for example, by taking an active part in setting priorities for our programmes (see also: ICRC, *Accountability to Affected People – Institutional Framework*).

All actors concerned need to ensure that emergency health responses are guided strictly by a comprehensive, impartial, and evolving assessment of needs. This requires the involvement of our local counterparts, the people affected and the ICRC's first aid and PHEC team. It is important to avoid prioritizing certain activities just because it is easy to develop them and measure their effectiveness, and to focus programmes and resources on the main emergency health issues in each particular context. Local coping mechanisms and local first-aid response systems need to be better assessed, understood, and addressed by means of a jointly conducted – and effective – first-aid programme. Given the number of protracted crises or recrudescent/recurring conflicts, there is also a need to think about how local first-aid guidelines and procedures can be adapted and updated as necessary, rather than seek to implement standardized and mostly Westernized approaches. This overview describes the ICRC's approach to first aid training, the flexibility of this approach, and the importance of conducting a proper assessment before undertaking any first aid activities (not only training); it also explains why we strongly recommend following the **results-based management** (RBM) model.

2.3 EMPOWERMENT OF THE EMERGENCY-CARE RESPONDER

An **emergency-care responder** is someone who is likely to be present at the scene of an emergency, and who has enough confidence and the skills necessary to tend to people affected. Emergency-care responders can be divided into four categories:

- **first-aiders** (trained in basic first aid) – in the community, and among weapon bearers, demonstrators, workers, etc.
- **first responders** (qualified in advanced first aid) – members of an emergency-response organization, such as a National Society, and civil defence staff, ambulance-service personnel (including informal service providers), health ministry officials, etc.
- **volunteer ambulance-service personnel** (trained in basic ambulance care) – ambulance lay responders who can be embedded in a variety of organizations/set-ups from a larger organization like a National Society or just function on a very small/individual level as community-based ambulance responders.
- **others** (such as people who are even more qualified: professional ambulance responders, EMTs and paramedics) – this group is trained and supported through the ICRC's PHEC programme, but will also have to undergo first-aid training.

Emergency-care responders can be any of the following:

- members of the general population, community and influential or trusted persons (e.g. political, religious or financial leaders)
- weapon bearers (state and non-state)
- Movement staff and volunteers
- public and private emergency-service providers
- certain groups of people (e.g. demonstrators, journalists, religious assemblies, NGO staff, demining groups, migrants/refugees, women and youth clubs, community cooperatives, shopkeepers, hotel staff, workers)
- ambulance personnel, taxi-drivers, and others mobilized to transport/evacuate wounded or acutely sick people
- community-based health-care workers, health-care personnel (dispensaries, clinics, hospitals), traditional healers.

An emergency-care responder should *not regard themselves as "a saviour, managing or resolving the situation by themselves"* or conduct themselves in such a manner. Instead, they should seek to realize the following objectives:

- **security**: by involving the crowd of bystanders, relatives, and/or friends, in order to limit chaos and mitigate potential risks
- **humanity**: by ensuring dialogue, basic psychosocial support and respect for the privacy and dignity of the people at the scene of the emergency, and respect also for humanitarian values and principles
- **efficiency**: by mobilizing people and, whenever necessary, by making effective use of the resources available
- **resilience**: by ensuring that people present at the scene of an emergency can exercise their own capacity to act in such circumstances
- **continuum of care**: by making sure that wounded or sick people are cared for, from the scene of the emergency until their recovery or while they are evacuated/transported elsewhere for further care
- **respect**: that is, ensuring respect for the wounded or sick person and for the people tending to them all along the patient journey; and ensuring respect for the protective red cross, red crescent and red crystal emblems as well. Responders should be aware that the patient could be their loved ones, or even themselves in the future and should treat them as they would wish to be treated.

The consequences of these achievements might become apparent later and elsewhere: for instance, they may lead people to become first aiders in their communities, or even National Society first aid volunteers.

Empowerment of the emergency-care responder should:

- include responding to the **needs** expressed by the emergency-care responders, and the capabilities identified by others
- be endorsed by the authorities/ leaders concerned or other **actors and sources of influence**[3]
- be adapted to the **characteristics of that specific emergency-care responder**[4]
- never lose sight of the fact that **first aid seeks to preserve life**, and thus preservation of life should be a matter of priority in whatever support or advice is offered.

In order to ensure that casualties get the assistance they need, the emergency-care responder should be motivated, and confident. They should have the ability to perform all their tasks in a **safe, humane and efficient** way. Finally, they should be able to display all these characteristics at the place and time of emergency situations. Training in these areas will bring the emergency-care responders closer to the realities they may face during emergencies.
The **main elements** to incorporate in any programme or project to develop and strengthen necessary skills are listed below:[5]

- safety and security management[6] (management of the scene of an emergency, self-management of stress and when relevant, dealing with weapon contamination or infectious diseases)
- basic life-saving and stabilizing measures (wound dressing, provision of physical and psychological care for a wounded person)
- basic psychosocial support (reassurance, empathy, communication/ explanation of steps taken to provide immediate medical attention and what the wounded person can expect to happen next, and seek their consent)
- mobilization of bystanders and use of local resources
- transport/ evacuation (for further care when necessary and possible)

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3 Actors from various spheres (political, religious, financial, etc.); 'means of influence' refers to the various sources, such as social media and communities, that are influential in that context.

4 Actors from various spheres (political, religious, financial, etc.); 'means of influence' refers to the various sources, such as social media and communities, that are influential in that context.

5 These elements must be adapted to local circumstances, as these will depend upon many factors, including possibilities for evacuation, quality and functioning of referral health structures, etc.

6 With guidance from the Safer Access Framework as well: http://saferaccess.icrc.org.

- ensuring respect for the red cross, red crescent and red crystal emblems and for every casualty and care provider, including the emergency-care responder
- ensuring the well-being of the care provider (which includes reassuring his or her relatives and friends)
- whenever relevant, the basic elements of dead-body management.

Empowerment of emergency-care responders therefore entails provision of **a comprehensive package of knowledge, attitudes and skills**, for use in a holistic way during an emergency.

2.4 CHAIN OF CASUALTY CARE

As the first link in the **casualty care chain**, first aid is crucial for another reason: it is also the first point of access to the health-care system. Optimal management of the wounded requires a **continuum of care** from the point of wounding or injury to their stay in hospital, and up to when the patients are back in their communities. Hospitals would like patients to have been properly stabilized before their arrival, in a timely manner and in order of priority. To learn how this can be achieved, it is necessary to keep this in mind: first aid is the initial assistance given to an injured or sick person until his or her condition has been stabilized or remedied, or a higher level of care – for instance, a hospital – can be reached, or professional medical help is made available.

What level of first aid is available and how first aid is delivered varies according to security conditions; the number and condition of the wounded; the resources that can be mobilized; transport capacity; the availability of emergency medical services (EMS); access to further care, or the availability of such care, and the capacities of secondary-care facilities.

Since its inception, the Movement has been associated mainly with first aid provision. It pioneered the concept of providing an immediate response to the consequences of wars, disasters and epidemics, by first-aiders and local communities.

The goals of an ICRC first-aider are:

- to intervene safely and securely
- to preserve life by supporting vital systems of the body

- to limit the effect of injury and to prevent further injuries
- to prevent complications and disability
- to provide psychosocial/moral support and alleviate suffering
- to promote recovery
- to ensure proper handover of the injured and the sick to the next level of care or to health-care professionals.

First-aiders can also help mobilize their community to prepare for and respond to daily emergencies or to those that arise during crises such as armed conflict or other violence. Decades of ICRC experience have shown that the pre-hospital phase is vitally important in determining the fate of the war-wounded. **It is an irrefutable truth that first aid saves lives and decreases morbidity**. Effective first aid reduces the burden on hospitals by making it easier for them to provide surgery and other forms of medical attention.

First aid provision is one of the fundamental responsibilities of military medical services, National Societies and, increasingly in contemporary armed conflicts, of medical staff in both rural and urban public hospitals. Local communities play an essential role in providing assistance on the spot, as witnessed by Henry Dunant after the battle of Solferino on 24 June 1859. Dunant was one of the founders of the Red Cross and the inspiration for the original Geneva Convention of 1864.

Consequently, support for basic first-aid training – both initial and refresher – should be provided to:

- the general population (community-based first aid)
- soldiers and members of security forces
- non-State armed groups and opposition groups
- community-based health workers (including ambulance personnel)
- military and other military medical services.

It is safe to assume that military commanders will not want to diminish their fighting capacity by using healthy troops to transfer their wounded comrades, only because of the inadequacy of first aid services in the field.

Advanced first-aid training can be added to the curriculum of those already trained in basic first aid and whose specific task it is to provide first aid in the field, such as military medics and National Society first-aid teams.

First aid in the chain of casualty care

First aid starts at the point of wounding or injury, can be given throughout the casualty care chain, until the site of definitive treatment.

Point of wounding

On-the-spot first aid is often administered on the battlefield itself; combatants and other weapon bearers may give it to themselves or to their comrades, if they have received the appropriate first-aid training. Otherwise, first aid is provided by military medics and National Society first-aiders or other civilians.

Collection point

It is common practice, and convenient, to bring all the wounded to one spot, when the situation permits it. This gathering together of casualties enables the following: effective evaluation of their condition; first aid provision if that has not already happened; stabilization for those for whom life-saving measures have already been taken; and finally, the making of decisions about who needs to be evacuated for further treatment – in accordance with triage priorities. A first-aid post is needed for this process to be most effective: therefore, instruction in setting up and running a first-aid post may also form a part of first aid training.

Evacuation

The decision to transport a wounded person should be taken only after a detailed assessment, because of the dangers and difficulties inherent in situations of armed conflict. Regardless of the means of transport used along the casualty care chain, first aid measures should be maintained throughout. Patient referral is taught in advanced first-aid training and in basic training for ambulance personnel.

Hospital emergency room

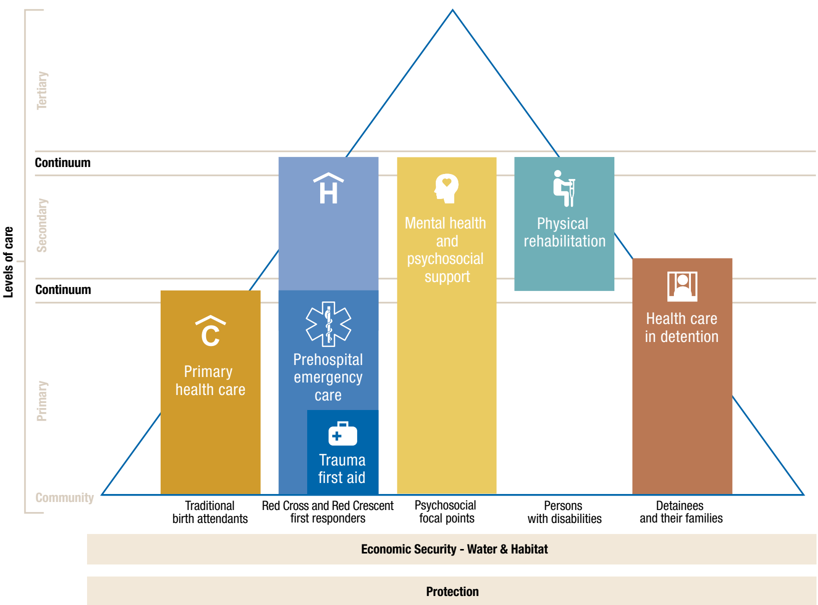
In the rural areas of poor countries and during urban warfare, the first place where any professional care is available is often the emergency reception of an established hospital. Even when there is an efficient emergency transport service, families and neighbours often do not wait for it; they prefer to transport their wounded relative or neighbour directly to a hospital, where the emergency room then serves as a first-aid post.

Chain of casualty care for the wounded and the acutely sick

	Facility/Location	Level of care provided	Health staff
↓	**1. On the spot** - Site of the emergency stabilization measures	**First aid**: immediate life-saving and responder	First-aider/ Emergency-care
↓	**2. Collection point** - First-aid post or other health facility	**First medical care**: emergency medical stabilization and referral of severely wounded people OR treatment and discharge of those with minor wounds	Advanced first-aider/ Skilled health staff
↓	**3. Intermediate stage** - Field or district hospital, or other health facility	**First surgical treatment**: wound excision	Trained medical and surgical staff
↓	**4. Surgical hospital**	**Definitive surgical treatment**: delayed primary-wound closure	Surgical teams
	5. Specialized centre - Physical rehabilitation centre, as well as orthopaedic centre	**Reconstructive surgery and physical rehabilitation**	Specialist teams

The ICRC's Health Unit takes a holistic approach to health that is both multi-disciplinary and people-centric. It defines the **'continuum of care'** as the comprehensive services or programmes/projects that address the health needs and well-being of a person, from the identification of a health condition until the recovery of a functional state consistent with the context.

ICRC Continuum of care



The **continuum-of-care** approach draws on expertise from every health programme, including first aid, and connects with areas beyond health, such as infrastructure, water and sanitation, economic security, and protection.

The health status of populations is the result of several interlinked factors, and understanding it requires a multidisciplinary assessment of the needs and risks, the resources available, and protective factors. It follows from this that operational programmes that target critical gaps, and address a range of social determinants for a given health issue, will have the most impact. The ICRC's first aid and pre-hospital emergency care programme strives to close gaps in access to heath care, in pre-hospital emergency care, and in referral services.

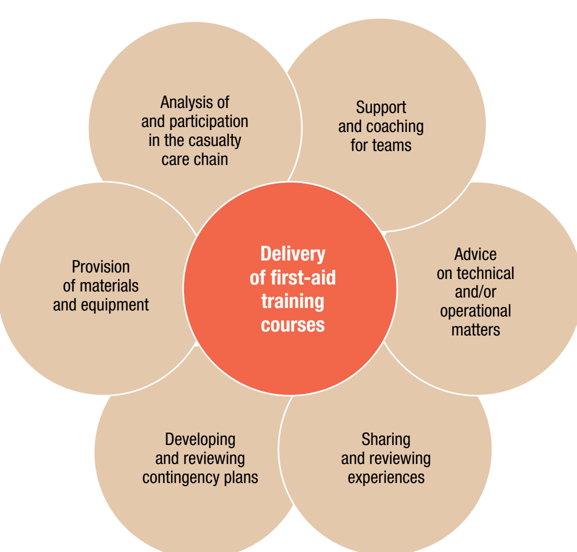
Continuum of care does not mean a continuum of ICRC operations. The ICRC does not therefore need to be active in all areas of its programming in each given context. It must, however, be able to identify and link actors that support the continuum of care for the target population.

First aid and pre-hospital emergency care have become, in conflict-affected contexts, something of a front line for numerous critical international humanitarian law (IHL) and policy issues: the denial of first aid or pre-hospital care as a tactic of war; the abrogation of neutrality by military first responders; the involvement of the private sector in frontline pre-hospital emergency responses; and disregard for the principles of precaution, distinction and proportionality in the conduct of hostilities.

One of the key objectives of the ICRC's Health Unit, and therefore a key objective of the pre-hospital and first aid programme as well, is to contribute to protecting the right to health of people in need. Progression along the casualty care chain starts with access to basic first aid from laypersons and/or access to a referral system for pre-hospital emergency care. In conflict-affected contexts, between 40 and 60% of all injured civilians and weapon bearers do not require hospitalization: basic first aid and simple oral antibiotics and analgesics are all they need. Simple and effective first aid systems can and should therefore be at the forefront of any health-care response for conflict-affected people.

3. THE ICRC FIRST-AID PROGRAMME: WHAT WE OFFER

First aid in the ICRC context should not be understood to mean just a set of bandages or lists of equipment, or a series of training courses. Its perspective is much broader: it includes operational issues (contingency planning, laws and regulations, security management, developing response and referral systems with the field actors, logistics, follow-up and monitoring, etc.) and multi-dimensional human values (coping resources, engagement spirit, psychosocial issues, resourcefulness etc.). The first-aid training programme seeks to further develop and/or strengthen people and organizations involved in emergency preparedness and response, especially in contexts that are sensitive and insecure or where resources are limited. It is prepared to augment, support and/or carry out the activities described below.



3.1 DELIVERY OF TRAINING COURSES

Before undertaking any activities in a particular context, the ICRC carries out a needs assessment and analysis; this is the case throughout the organization. After the needs assessment and analysis it will seek to undertake or support those activities that can be adapted to the needs of the target group(s). One of these activities will usually be educational, such as training in basic and/or advanced first aid. For the purpose of this overview, the training activities mentioned below are for **first-aid training only**: PHEC training for qualified pre-hospital health personnel (e.g. paramedics, EMTs, ambulance nurses and/or pre-hospital emergency physicians) and other skilled health professionals will be outlined in the PHEC guidelines.

The decision to offer basic or advanced first-aid training will depend on the knowledge and proficiency of participants. This must be evaluated during the first aid needs assessment that is carried out before implementing any first aid -related activities. Advanced first-aid training can be offered only to participants who have mastered all aspects of basic first aid; they must also have a background in formal or informal medicine. Passing a course in basic first aid does not automatically qualify someone for advanced first-aid training.

People involved in the continuum of care for the wounded and the acutely sick will encounter numerous challenges when treating and transporting casualties from scene of an emergency to a collection point or site of intermediate care. They must be empowered to think creatively (the how and why) and focus on essential action-related principles and limits (the what). This will enable them to make decisions that are safe and effective – before, during, and after the emergency response.

Standard ICRC training in basic first aid aims to empower the first-aider to be motivated, confident and skilled to perform all aspects of basic first aid in a manner that is **safe, humane and efficient**. This goal can be achieved only if the approach to training is **pragmatic, realistic and eclectic**. ICRC training workshops in first aid (for all service providers) are grounded in practice rather than theory: they involve simulations/practices that are closely aligned to the realities that participants have to deal with. Case simulations are designed and prepared by the ICRC first-aid delegate and/or first-aid field officer; and ICRC first-aid training usually focuses on **trauma** and **traumatic injuries**, which are typical of the contexts in which the organization works.

ICRC Basic First-Aid Training Programmes

First-Aid Training	Contents	Duration in days (8 hours/ day)	Number of participants (max.)	Trainer/Provider
Basic First Aid	Standard ICRC first-aid training	2–3 days (16–24 hours)	20	Can be provided by one trainer (first-aid delegate or senior first-aid field officer if adequately qualified) plus 1 or 2 co-trainers/co-facilitators (The facilitator must be a first-aid trainer)
Basic First Aid: *Refresher*	Standard ICRC refresher training in first aid	1–2 days (8–16 hours)	20	Can be provided by one trainer (first-aid delegate or senior first-aid field officer if adequately qualified) plus 1 or 2 co-trainers/co-facilitators (The facilitator must be a first-aid trainer)
Training of Trainers in Basic First Aid	Training methodology for first-aid trainers	5 days (40 hours)	15	Can be provided by one trainer (first-aid delegate or senior first-aid field officer if adequately qualified) plus 1 or 2 co-trainers/co-facilitators (The facilitator must be qualified to conduct train-the-trainers sessions, and the co-trainers/co-facilitators must at least be first-aid trainers)
Training of Trainers in Basic First Aid: *Refresher*	Refresher sessions in training methodology for first-aid trainers	2–3 days (16–24 hours)	15	Can be provided by one trainer (first-aid delegate or senior first-aid field officer if adequately qualified) plus 1 or 2 co-trainers/co-facilitators (The facilitator must be qualified to conduct train-the-trainers sessions, and the co-trainers/co-facilitators must at least be first-aid trainers)
Comments	This type of BASIC FIRST-AID TRAINING currently accounts for 70% of all ICRC first-aid training. Successful participants are referred to as “qualified first-aiders”.			

ICRC Advanced First-Aid Training Programmes

First-Aid Training	Contents	Duration in days (8 hours/ day)	Number of participants (max.)	Trainer/Provider
Advanced First Aid	Advanced (medically based) first-aid training	2–3 days (16–24 hours)	15	Can be provided by one trainer (first-aid delegate or senior first-aid field officer if adequately qualified) plus 1 co-trainer/co-facilitator (The facilitator must be a first-aid trainer and have a medical background)
Advanced First Aid: *Refresher*	Refresher training (medically based) in advanced first aid	1–2 days (8–16 hours)	15	Can be provided by one trainer (first-aid delegate or senior first-aid field officer if adequately qualified) plus 1 co-trainer/co-facilitator (The facilitator must be a first-aid trainer and have a medical background)
Training of Trainers in Advanced First Aid	Training methodology for trainers in advanced first aid	5–7 days (40–56 hours)	10	Can be provided by one trainer (first-aid delegate or senior first-aid field officer if adequately qualified) plus 1 co-trainer/co-facilitator (The facilitator must be a qualified master trainer in first aid, and the co-trainer/co-facilitator must be at least a trainer of trainers; both should have a medical background)
Training of Trainers in Advanced First Aid: Refresher	Refresher sessions in training methodology for trainers in advanced first aid	2–3 days (16–24 hours)	10	Can be provided by one trainer (first-aid delegate or senior first-aid field officer if adequately qualified) plus 1 co-trainer/co-facilitator. (The facilitator must be a qualified master trainer in first aid, and the co-trainer/co-facilitator must be at least a trainer of trainers; both should have a medical background)
Comments	To be delivered only to medical/emergency-medical-care professionals and/or to people with long-standing involvement in first aid, like senior National Society first aid volunteers or trainers capable of managing all aspects of basic first aid. Successful participants are referred to as “qualified first responders”.			

All service providers will be trained in first aid via the systematic approach shown below.

Systematic approach	
Danger	"Think Safety, Act Safely" Manage your scene by protecting yourself from harm, being aware of actual and potential hazards, and moving yourself and any casualties away from danger. Apply triage principles in mass-casualty situations. Avoid becoming another casualty.
Response, consent and cooperation	Check casualty response, gain consent and ensure cooperation of the casualty. Respect dignity and confidentiality, and provide comfort and reassurance.
Seek help	Mobilize bystanders and relevant services.
A-B-C-D-E Approach	Identify and address life-threatening issues associated with the following: A – Airway B – Breathing C – Circulation D – Disability E – Exposure.
Complete examination	Head-to-toe evaluation of the casualty. Look, listen, feel and ask to determine or detect further injury.
Treatment, care and monitoring	Provide appropriate treatment, support, care, and comfort. Re-evaluate the casualty constantly for changes in condition.
Handover and debriefing	Hand over casualty to the next level of care when necessary. Take part in a debriefing session to evaluate, reflect, relax and learn.

Management of security issues related specifically to armed conflict *(in a confined space, in a room full of smoke, during protests or conflict, after an explosion, during an attack, under fire, etc.) is a* ***component of all training in trauma first aid*** *offered by the ICRC.*

First-aid training by the ICRC will also involve training in managing certain kinds of context-specific cases. However, this will generally involve some of the following situations:

Managing a situation where a person is:
- unresponsive (topics may include management of head trauma, babies/ children, absence of spontaneous breathing, etc.)
- bleeding (topics may include management of large bleeding areas, compressive bandaging, deep-wound packing, dizziness, amputation, tourniquet, post-delivery bleeding, etc.)
- suffering from burns (topics may include management of victims' clothes that are still on fire, clothes clinging to burnt areas of skin, burns on different parts of the body, burns of different kinds, etc.)
- suffering from a fracture (topics may include management of open fractures, fractures associated with bleeding or unconsciousness, use of such things as tree branches or cardboard for splinting)
- suffering from a wound (topics may include management of animal bites, weapon-related injuries, infected wounds, shortages of wound-dressing materials, etc.).

Every session[7] is structured around four successive stages:
- **EXPLORATION** – Sharing of expectations, experiences and ideas among all the participants (including the facilitator) through real-life scenarios and storytelling
- **HARMONIZATION** – Identification of the elements essential for providing a safe, humane and effective response[8]
- **CONSOLIDATION** – Consolidation of learning experiences and consolidation of clinical techniques through a variety of situations/ scenarios in various contexts

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7 Each session of a training course is titled "The management of an emergency situation where a person suffers from ...", and not "The technique to apply in case of injury...": the former gives a clearer description of the session's aims.

8 This refers to the intended result of an action based on signs that are visible and can be evaluated. For instance, with regard to burns, it means controlling the pain and avoiding infection, without doing harm or being harmed. In other cases this will mean: unconsciousness (passage of the air), bleeding (visible blood), fracture (localized pain), wound (opened skin). Furthermore, part of the building of the confidence and the efficiency is to not distinguish between the different bleedings and burn degrees, as the action is the same for any bleeding and for any burn.

- **CONCLUSION** – Conclusion completed with a commitment for continuation and some aspects related to prevention.

The duration of a first-aid training course and its content depend on:
- the availability of the participants (poor security conditions might limit participation), and their needs and capacities
- the best outcomes feasible.

The training should not be an end in itself. Mobile apps or Web-based support, or virtual-reality tools, cannot cover all needs, expectations and realities. Training should be regarded as one component of a **continuous effort** to reinforce the confidence and skills necessary to provide an effective response, and to take advantage of the gains made – that is, the results achieved – and the lessons learned. **Various methods, channels and resources must be used, at different times, to raise awareness and empower people and never create dependence on just one training method**.

Any support provided by the ICRC should:
- respect the level of access (e.g. with or without IT)[9]
- reflect what generally attracts people and holds their attention or interest, and keeps them active (e.g. game-like, interactivity)
- be in a language and form that the target audience can grasp easily
- address the main aspects of preventing and responding to an emergency (not just the skills and materials used).

Some examples of education/training support are listed below:
- group discussions, theatre, songs, radio spots, TV shows, drawings, photos
- media, public event, places where relatives and friends waiting in referral health-care facilities
- first aid services/posts (e.g. during a response to an emergency, a National Society first-aider can act as an intermediary or go-between for the casualty and bystanders)
- regular meetings, briefing and debriefing sessions (covering operational and emotional aspects), lessons-learnt exercises, meetings with others in the chain of emergency care

9 Remember that people with an internet connection look for information mainly via internet search engines and social media. That may lead to some confusion or cause confrontations, because their sources of information may be contradictory or unreliable (even when they claim to be scientific).

- simulation exercises, updates and upgrades – based on the experiences gained, and carried out regularly
- dedicated mobile apps and web pages
- virtual-reality tools.

Management of dead bodies

If the needs assessment finds that it is necessary, management of dead bodies[10] can be included in basic and advanced first aid-related educational activities. First-aid training will cover the main aspects: collecting dead bodies; protecting the bodies and the emergency-care responders; recording all pertinent information obtainable from the bodies; and tracking the bodies. The training will also cover such matters as health and safety measures, security precautions, and respecting and ensuring respect for the dead and the bereaved. The following will be emphasized:

- bodies do not create epidemics; avoid/prevent hasty disposal (burial/cremation) of dead bodies
- the dead and the bereaved should always be shown due regard
- know your limits and don't be afraid of them: know when to respond and when to stop
- ambulances must not be used to move human remains, as they are best employed to transport the wounded and the acutely sick.

Please refer to the manual recommended in footnote 10 for further details.

3.2 TECHNICAL SUPPORT

The ICRC must ensure that it is agile and that its programmes remain relevant, up-to-date and where possible, evidence-based and widely accepted. Therefore, a key component of the ICRC's first-aid training programme, and a key function of the ICRC's first-aid delegates and field officers, and of the first-aid coordination team at headquarters, is the provision of technical guidance and advice for the actors with whom we work. Provision of technical support will be a thread running through the programme, but there may be specific areas of focus, such as:

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10 A detailed description of the procedures that must be followed, together with numerous recommendations, can be found in this guide: PAHO/WHO, ICRC, IFRC, *Management of Dead Bodies after Disasters: A Field Manual for First Responders*, Geneva, 2016: https://shop.icrc.org/management-of-dead-bodies-after-disasters-a-field-manual-for-first-responders-pdf-en

- analysis of the casualty care chain and the continuum of care
- development and/or review of contingency plans (including plans for dealing with major incidents/mass casualties)
- training and curriculum development (review or provision of advice)
- materials and equipment (review or provision of advice)
- updates for best practices
- data collection, analysis and mapping
- advice for matters related to communication
- Health Care in Danger (HCiD) and the Safer Access Framework.

Analysis of the casualty care chain

To ensure that there is an effective, functioning and fully understood care pathway, the ICRC first-aid team may wish to undertake an analysis of the casualty care chain, the continuum of care, and referral systems. This analysis will look at the casualty care chain from point of incident to definitive care (see 2.4) and will assess the populations affected, key stakeholders, facilities available and existing capabilities, and any gaps in the continuum that may need to be addressed.

Contingency planning

Together with the wider health team, other ICRC specialists and key actors, the ICRC first-aid team may provide support and advice for developing or reviewing contingency planning. This may include advice on emergency preparedness, disaster planning, and management of major incidents or mass casualties.

Training and curriculum

The ICRC first-aid team may be involved in developing, reviewing or updating first-aid training standards, curricula and teaching/educational practices used by actors in their various contexts. These updates will reflect the needs of the population and the skills of service providers, and incorporate the latest widely accepted practices and guidelines where appropriate. The ICRC first-aid team will remain connected to a wider network to ensure their awareness of the latest developments in their field.

Materials and equipment

The ICRC first-aid team may be involved in reviewing, updating or making recommendations in connection with first aid materials and equipment (for operations and/or training) being used by actors in their various contexts, or

with regard to plans for obtaining such materials and equipment. The support and/or recommendations provided by the ICRC's first aid experts will reflect the context (resources available), the skills of service providers, and the needs of the population affected. It may include advice on future, sustainable planning.

Best practices

The ICRC's first-aid team seeks to ensure that everybody who needs first aid will get it. To realize this objective we strive to make sure that the first-aid training we provide is up to date and delivered by qualified trainers. The ICRC's first-aid programme also strives to ensure adequate first aid provision in armed conflict and the existence of context-specific equipment and competent individuals within the population affected. At ICRC headquarters the programme in trauma first aid is evaluated and modified periodically, to keep it up to date: this includes periodic assessments of the ICRC's first-aid training courses. The ICRC's first-aid guidelines set out the elements necessary for first-aid programmes to be feasible, effective, and sustainable for each given context.

Data collection and analysis

To support the delivery of services and to ensure efficiency and pertinence, the ICRC's first-aid team may collect and analyse data to make changes in programmes or set priorities for them. It may use statistics and other data to:

- provide cost-benefit and cost-efficiency analyses
- ensure that people affected are being adequately served (i.e. monitoring and follow-up)
- understand trends in public health
- map stakeholders and facilities
- understand populations and demographics
- collect response- and referral-related information
- improve the quality of a particular service.

Communication

To support training and service delivery, the ICRC's first-aid team may provide technical assistance or advice, in conjunction with the communications team, for raising awareness of programmes and services and promoting them. This may include assistance in developing awareness campaigns and/or promotional activities, and may even extend to providing advice for formulating operational communication and dispatch protocols (and services).

Health Care in Danger (HCiD) and the Safer Access Framework
Together with the wider health team and other ICRC specialists, the ICRC's first-aid team will ensure that raising awareness of HCiD, and reporting on matters related to it, remains a priority and that people affected have safe access to health care and the support provided by the first-aid programme. HCiD statistics are reported as part of the first aid's monthly submission of data to the medical activity database.

3.3 SHARING AND REVIEWING EXPERIENCES

Representatives of the ICRC first-aid team will use their expertise and network of contacts to share and review experiences among contexts and projects around the world, with a view to reviewing practices, exchanging ideas and of course, applying lessons learned.

Put simply, lessons learned is a term used to describe the general process of learning from experience to make improvements to something or someone. Success for a lessons learned process can be defined more elaborately like this: an increase in capacities or performance – confirmed when necessary – as a result of the implementation of one or more remedial actions for a clearly identified deficiency.

For an organization, the idea is that, through a formal approach to learning – lessons learned – individuals and the organization can reduce the risk of repeating mistakes and improve future processes. In the first aid and PHEC context this means reducing operational errors, making care more effective, increasing cost efficiency, and focusing on improving patient outcomes.

Lessons learned means more than just learning from experience. The purpose of a lessons learned process is to learn efficiently from experience and provide justification for changing the existing way of doing things, in order to improve first aid provision. This requires that the lessons be meaningful and brought to the attention of the decision makers concerned.

- Everyone within the target group needs to be involved for a lessons learned process to be successful.
- A lesson cannot be said to have been learnt until something changes in the way we operate; and the ones who need to change are the ones implicated in an issue: the stakeholders.

- Operational volunteers/staff (first-aiders and first responders) must be the ones who learn.
- First-aiders and first responders are usually the first, and often the only operational personnel likely to be aware of the lessons to be learnt, because they are the ones most closely involved with the issue in question.
- Unless these potential lessons are submitted via a clearly defined lessons learned process, it is unlikely that any managerial or operational staff will be able to discover their existence in order to even begin the learning process.
- All stakeholders must share the lessons they have identified.

Everyone in an organization has a duty to learn lessons, so to speak, but a lessons learned working group is vitally important role to play in ensuring that everybody understands how valuable the lessons learned process is. To learn more about the technical aspects of the ICRC's recommended lessons learned exercise, contact an first-aid delegate or the first-aid coordination team at ICRC headquarters.

3.4 PROVISION OF MATERIALS, EQUIPMENT AND FUNDS

The ICRC may need to provide material or financial support to ensure effective delivery of first aid. Donations may be provided to support training courses or sessions, responders and response teams, and even certain promotional activities. Provision of supplies will be **based on need**, and will take into account **requisite skills, sustainability and availability**. A detailed list of all the supply options will be available from the first-aid delegate concerned. The chart below provides a number of examples.

Activity	Material support	Financial or other support
Training and response	- First aid kits (equipped with basic first aid materials) - Basic medicines - Stretchers - Mannequins - Moulage items - Uniforms	- Per diem allowances - Meals or refreshments - Travel costs - Funds for hiring venues - External training and certification - MHPSS - Exposure missions and internship opportunities
Operations	- Vehicles - Communication equipment and infrastructure - Cleaning and decontamination supplies - Safety equipment	- Fuel costs - Mechanical, engineering and IT support - Fleet advice - External training and certification - Exposure missions and intern opportunities
Administration	- IT equipment - Office supplies	- Budgetary support - Printing (certificates)
Promotion	- Booklets and flyers	- Advertising - Emblems and decals

4. THE ICRC FIRST-AID PROGRAMME: WITH WHOM WE WORK

4.1 FIRST AID FOR WEAPON BEARERS

Caring for wounded weapon bearers during armed conflict and other situations of violence ***is a foundational element of the ICRC's identity***. ICRC and National Society first-aiders are among the few actors who can provide assistance in such circumstances. In accordance with its mandate, the ICRC works with other organizations – and with governments, weapon bearers, non-state armed groups and civil society – to protect and assist victims on all sides of an armed conflict. IHL obliges all parties to conflict to collect and care for the sick and the wounded, and to treat them humanely. Wounded weapons bearers who are no longer directly participating in hostilities must also be protected and assisted.

Today, there are National Societies in most countries,[11] and weapon bearers of different kinds often have well-developed medical corps to assist their wounded in times of conflict. There are many first-aiders, medical corps, and domestic and international laws trained or developed specifically to assist and protect wounded weapon bearers; however, the ICRC may need to provide first aid and other support for wounded weapons bearers when:

- first aid or other services for wounded weapon bearers are inadequate or non-existent, or when access to timely civilian services is limited or non-existent because of the terrain or owing to political circumstances or security conditions
- the needs of the wounded are unmet, and when they are inaccessible to National Society first-aiders for various reasons: the terrain; political circumstances; security conditions; or scepticism about the neutrality and impartiality of the National Society in question
- medical staff – stretcher-bearers, first-aiders, medics, nurses, doctors or surgeons from one or more parties to conflict – are faced with injuries or wounds that are new to them; shortages of supplies; or unexpected surges in the casualty rate

11 For a list of National Societies and their contact details, please see: http://www.ifrc.org/en/what-we-do/where-we-work/

- first-aiders or other medical personnel from one or more parties to conflict, their medical facilities, or the wounded in their care are attacked (see the section on HCiD in 3.2.)
- such support is required to improve the quality of care (because of the employment of harmful methods such as prolonged tourniquet use; incorrect treatment; little or no triage; inefficient referral systems; little or no emergency preparedness and/or plans) and/or to improve the quality of instruction or training in first aid
- knowledge of various vital matters is lacking: for instance, the respect and protection due, under IHL, to medical staff, facilities and vehicles not involved in hostilities; the role of the ICRC; and measures that provide more effective physical protection for first-aiders and other medical personnel, their patients, and their assets.

From a medical perspective, these are the most important aspects of care provision for weapon bearers wounded during hostilities: **prompt and adequate trauma first aid and stabilization measures at the point of injury or in the safest place near the battlefield (e.g. first aid posts), and rapid evacuation**. An efficient casualty care chain for the wounded will offer these measures; they *save lives, reduce complications and disability, and facilitate surgery.* With regard to civilians wounded during urban violence, timely life-saving and stabilization measures, plus a simple oral antibiotic and painkiller, are sufficient to treat more than 50% of all those admitted to hospital.[12]

An efficient casualty care chain[13] for the wounded can save lives, reduce complications, prevent disability, and/or facilitate surgery. Depending on the context, weapon bearers can play a part throughout the continuum of care for wounded or acutely sick people, including civilians. Trauma first aid focuses most of the time on the battlefield and on collection points; but other kinds of care – PHEC, intermediate care, surgical care at hospitals and specialist care – must also be considered when taking decisions about support for trauma first aid. ICRC support for all these different kinds of care is generally managed separately from first-aid programmes. It is necessary that providers of these various kinds of care also be trained in first aid; it is therefore necessary for us to coordinate with our colleagues in other health programmes and to

12 C. Giannou and M.Baldan, *War Surgery: Working with Limited Resources in Armed Conflict and Other Situations of Violence*, 2nd ed., Vol. 1, ICRC, Geneva, 2019.

13 The chain of casualty care is the route followed by the wounded from the point of injury to specialized care.

stay abreast of other ICRC assistance activities that will have an impact on the casualty care chain for the wounded.

4.2 FIRST AID FOR COMMUNITIES

Communities are the backbone of first-aid response and service provision in almost all contexts; they facilitate and support all stages of the continuum of care for wounded and acutely sick people (see figure on p. 31). When a crisis or emergency presents itself, it is the community that first provides essential aid – like stopping the flow of blood from a wound or offering much-needed comfort. The ICRC – alone or with partners – delivers first-aid training in communities throughout the world, to ensure they are equipped with life-saving knowledge and skills, and the confidence to act when needed. Communities – particularly in those contexts where the ICRC operates – can play a pivotal role in reducing morbidity and mortality among wounded and acutely sick people. Communities are, by definition, groups of people who live in proximity to one another or share certain characteristics (such as suffering the consequences of the same event or incident). We hope that communities empowered in first aid will work towards a common objective: to alleviate pain and suffering and act as true humanitarians, during conflict and/or other emergencies. It is also the case that appropriate first-aid training helps communities and organizations prepare for crises and deal with them more effectively.

Members of the communities in which the ICRC operates – relatives, comrades-in-arms, ordinary bystanders, and/or National Society volunteers – are usually the first persons at the scene of an emergency and are subsequently the **first to be able to provide immediate assistance** to the wounded or the acutely sick.

Community empowerment in first aid helps save lives and alleviate suffering; but it can also broaden awareness and acceptance of the red cross/red crescent/red crystal emblem and health-care personnel in general.[14] In addition, the sustainability of activities related to disaster preparedness, and the resilience of communities during emergencies, can be strengthened through well designed, and properly targeted and implemented, first aid action (educational and operational). A detailed knowledge of all those involved in a response – including wounded and acutely sick people – is crucial for ensuring that the ICRC's first aid support reaches those people and groups who need it most.

14 In line with the HCiD initiative: www.healthcareindanger.org

ICRC vs IFRC/National Societies in Community First Aid Action

1. The IFRC and its National Society partners provide training in community-based health and first aid (CBHFA).
2. The ICRC works primarily in trauma-related first aid and does not include curative health care in its first-aid training.
3. Their working methods (or 'operating procedures', if you prefer that phrase) are not the same.

4.3 FIRST AID FOR AMBULANCE PERSONNEL

Ambulance and other transport services facilitate the evacuation of sick and wounded people. Particularly in the contexts in which the ICRC operates, these transport services cover a broad range, from lay ambulance services (e.g. rapid-taxi services) to medical ships and/or helicopters and planes. The ICRC's first aid and PHEC programmes must incorporate all lay ambulance services in order to ensure the best possible care and outcomes for those affected by armed conflict or other violence and/or other emergencies. As the first emergency-care responders qualified to provide advanced first aid and/or basic emergency medical care, ambulance personnel – during armed conflict – are often also involved in setting up first aid posts or medical posts (that is, anything from a patient-collection point to a medical post where some form of advanced care is available). Detailed knowledge of the environment and of the personnel that will be involved in evacuating sick and wounded people, and establishing medical posts, is a necessity: without such knowledge it will be difficult, if not impossible, to ensure that informal facilities providing first aid are identified and given the necessary ICRC support for first aid.

The level of training received by these emergency-care responders – from highly skilled services and professionally recognized staff to driver-only systems with no direct patient care during referral –varies widely from one country to another. Effective pre-hospital care is unavailable in many settings: one of the main reasons for this is the inability of responders to provide first aid for casualties.[15] The evidence shows that emergency-care responders and ambulance personnel can benefit from contextualized and appropriate first-aid train-

15 ICRC, *First Aid in Armed Conflicts and Other Situations of Violence*, ICRC, Geneva, 2006.

ing, particularly in settings where there is no formally structured and regulated pre-hospital education.[16] Such first-aid training could also lead to improved outcomes for patients in the critical phase between injury and definitive care.

The ICRC's first-aid programme's activities to benefit ambulance responders and services may include other things besides first-aid training, such as:

- providing safe access and addressing barriers to care and referral (for the wounded/sick and the care provider)
- ensuring the availability of the necessary resources of good quality
- monitoring and evaluating transport and referral systems
- contingency planning and/or emergency preparedness.

Ambulance and transport services should not have to restrict themselves to evacuating sick and wounded people; they should also be motivated and empowered to provide **emergency medical care**.

4.4 FIRST AID FOR NATIONAL SOCIETY VOLUNTEERS AND STAFF

Together, the National Societies, the IFRC, and the ICRC make available a unique pool of first-aiders, first responders and health professionals who work all over the world in a community-based network.[17] First-aiders and first responders are active not only during disasters and armed conflict or other violence; they also have daily tasks. Appropriate first-aid training and daily activities provide the basis for an effective and well-prepared response by National Societies in the event of disasters or armed conflict/other violence. Involving the people concerned in designing and implementing programmes ensures:

- responsiveness to needs
- preparedness and the capacity to prevent or manage emergencies (injuries, diseases)
- respect for local socio-cultural practices and religious beliefs.

The presence on the ground, and the daily work, of first-aiders and first responders – or of emergency-care responders in general – makes a statement about the humanitarian spirit linking peoples and communities. By demonstrating

16 S. Suryanto, V. Plummer, V and M. Boyle, "EMS systems in lower-middle income countries: A literature review", *Prehospital and Disaster Medicine*, 32(1).

17 Jennifer L. Pigoga et al., (2017). "Adapting the emergency first aid responder course for Zambia through curriculum mapping and blueprinting", *BMJ Open*, 7(12).

that "people help other people" all emergency-care responders set an example. The ICRC has an obligation – inspired by humanitarian principles and values – to ensure that all National Societies have the support they need to provide timely, impartial and effective first aid during conflict and other emergencies.

During armed conflict or other emergencies, **emergency medical care can often be inaccessible or unavailable** to casualties. There are various reasons for this, such as: insecurity; threats to health-care personnel; damage to the health-care system; and the destruction of ambulances. Any immediate assistance or transport/evacuation of casualties is provided by people present at the scene: relatives, comrades-in-arms, ordinary bystanders and/or local health-care personnel. This assistance, though essential, is often of poor quality: the persons concerned lack the knowledge or the ability to respond to emergencies of this kind; and the systems or structures in place are unprepared and under-resourced and unable to provide the services necessary.

Furthermore, it is often the case that **emergency services** (public, private, National Societies, NGOs) **do not have the capacities necessary** to respond in contexts characterized by a lack of security management; unpreparedness in handling emergencies; inability to work with limited resources and in isolation; shortage of supplies; and so on. **National Society first-aiders/first responders** are often the first organized responders on the scene, and depending on the context, sometimes, for a while, the only ones there. Very few **National Societies are adequately prepared or equipped** to cope with armed conflict/other violence, and other emergencies: they are almost always unable to ensure access for their first-aid teams or to guarantee their effectiveness. The National Societies that recently became involved frequently **find it difficult to incorporate lessons learned** in their strategies, contingency plans and routine work in connection with emergency preparedness and response.

In addition, the system for collecting, transporting and storing dead bodies often breaks down or is disrupted. Therefore, **the task of managing dead bodies** is often left to those present at the scene: ambulance personnel or other first responders and, almost everywhere, National Society first responders/first-aiders; these people carry out this task either because they are required by law to do so or because their help has been solicited for that occasion. In this connection, local sources of reference, awareness and skills are often inadequate or non-existent; this is also true of the materials and equipment required for managing dead bodies.

The ICRC's first-aid programme can incorporate all National Society staff and volunteers in operational contexts, to ensure the best possible care and outcomes for those affected by emergencies. National Societies can be complicated organizations with various affiliations. Close collaboration with the ICRC's Cooperation Division and with the red-line management at delegations is required to ensure that the ICRC's first-aid programmes and activities are relevant and well received. Depending on the context, a National Society can be involved in and/or responsible for the entire continuum of care for a wounded or acutely sick person. As per the continuum of care, National Societies can be involved in or responsible for:

- first response at the scene of an emergency (National Society volunteers)
- immediate care (National Society health posts and health facilities)
- transportation (National Society ambulance services)
- preparedness (National Society programmes in education and prevention for communities and others).

4.5 FIRST AID FOR HEALTH PROFESSIONALS

During conflict and other emergencies health professionals may be the first qualified people on the scene. It is therefore essential that they have a basic knowledge of the life-saving measures, outside the clinical context, that are currently in use. Appropriate first aid training and daily exercises prepare health professionals to respond effectively in the event of disasters or armed conflict/other violence. Involving the health professionals concerned in designing and implementing programmes ensures:

- responsiveness to needs
- preparedness and the capacity to prevent or manage emergencies (injuries, diseases)
- respect for local socio-cultural practices and religious beliefs.

Depending on their training, experience, capacities and motivation, skilled health professionals can, in principle, be first-aiders or emergency-care responders. The presence on the ground, and the daily work, of first-aiders and emergency-care responders makes a statement about the humanitarian spirit linking peoples and communities. By demonstrating that "people help other people", first-aiders and emergency-care responders set an example. In a functioning health system, health professionals provide health-care services in ordinary times; this gives them a unique position of trust and respect in communities. During emergencies, health professionals – community health

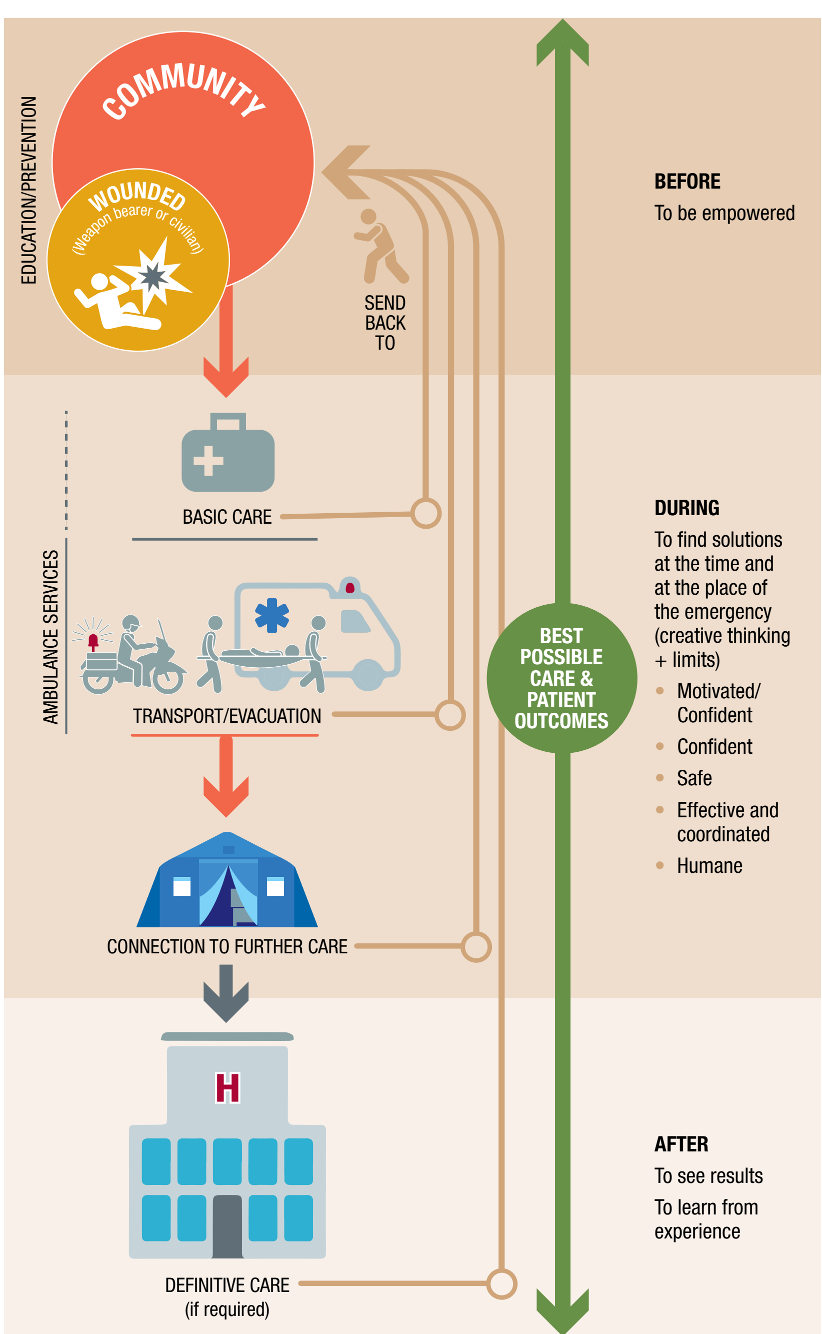
workers, traditional healers and other health-care personnel (dispensaries, clinics/hospitals) – will be expected to provide basic but effective care to the wounded and acutely sick, and they should be able to do so.

During armed conflict or other emergencies, **emergency medical care can often be inaccessible or unavailable** to casualties. There are various reasons for this, such as: insecurity; threats to health-care personnel; damage to the health-care system; and the destruction of ambulances. Any immediate assistance or transport/evacuation of casualties is provided by people present at the scene: relatives, comrades-in-arms, ordinary bystanders and/or local health-care personnel. This assistance, though essential, is often of poor quality: the persons concerned lack the knowledge or the ability to respond to emergencies of this kind; and the systems or structures in place are unprepared and under-resourced and unable to provide the services necessary.

Furthermore, it is often the case that **emergency services** (public, private, National Societies, NGOs) **do not have the capacities necessary** to respond in contexts characterized by a lack of security management; unpreparedness in handling emergencies; inability to work with limited resources and in isolation; shortage of supplies; and so on. Health professionals are often the first professional responders on the scene (in first-aid post, advanced medical post, casualty clearing station, etc.); and depending on the context, they are also often, for a while, the only ones with knowledge of emergency medicine on the scene. Health professionals who are not hospital staff are frequently unprepared or unequipped to cope with armed conflict/other violence, and other emergencies: they are almost always unable to ensure access to pre-hospital emergency medical care or to guarantee its effectiveness. They therefore need to have clearly defined first aid strategies and contingency plans with regard to their capacities in emergency preparedness and response, especially for out-of-hospital or off-duty situations.

The ICRC's first aid and PHEC programmes can incorporate health professionals at all levels, to ensure the best possible care and outcomes for those affected by emergencies in out-of-hospital settings of any kind. Depending on the context, health professionals can be involved in and/or responsible for the entire continuum of care for a wounded or acutely sick person. As per the continuum of care, National Societies can be involved in or responsible for:

- first response at the scene of an emergency (all health-care personnel, including traditional healers)
- immediate care (health professionals (doctors/nurses/EMTs/paramedics, etc.)
- transportation (EMS services)
- further care (includes a broad range of providers, from traditional healers to hospital staff; further-care options are context-dependent)
- preparedness (health professionals (clinic staff, dispensaries, doctors, nurses, traditional healers, etc.; programmes in education and prevention for communities and others).



Continuum of care for the wounded and the acutely sick.

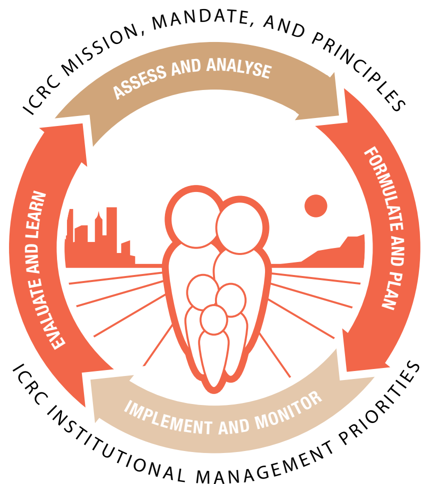
5. THE ICRC FIRST-AID PROGRAMME: HOW WE IMPLEMENT OUR PROGRAMMES

The ICRC's first-aid programmes and projects are developed according to the needs of the people affected and follow the RBM process. This ensures that every programme is necessary; properly planned; evaluated for effectiveness; and continuously improved. The ICRC's first-aid team works with many different groups of people affected and actors to ensure that gaps in care, equipment, knowledge or skills are adequately addressed in a manner that fits the context, and is effective and accountable.

5.1 RESULTS-BASED MANAGEMENT

The ICRC's RBM cycle is divided into four stages:
- assess and analyse
- formulate and plan
- implement and monitor
- review/evaluate and learn.

This cycle implies the necessity of having a clear understanding of the context in which we work (assess and analyse); defining the objectives that will address the needs identified through our assessment (formulate and plan); carrying out the actions required to achieve our objectives and keeping track of progress (implement and monitor); and assessing if our objectives are likely to be achieved/have been achieved, while also noting the reasons for our success or failure (review/evaluate and learn). First aid programming should follow the RBM approach, in order to strengthen its performance and its ability to demonstrate the effects of its activities.



All ICRC assistance activities must follow the RBM cycle in order to ensure project accountability and progress. Further information on the specifics of the RBM cycle can be found on the ICRC *Health Wiki*.

5.2 NEEDS ASSESSMENTS

A **needs assessment** is the first of the four phases of an RBM process. It is carried out to gain an understanding of the situation and the problems – their causes and consequences – and to determine whether there is a need for ICRC action and if so, what form that action should take. An assessment of the need for first aid and related support provides:

- a baseline for informed ICRC decision-making
- a baseline for monitoring and evaluating programme outcomes
- an understanding of stakeholders' roles and interests
- open dialogue with actors involved in health-related matters to facilitate ongoing assessments or monitoring of evolving needs, and an opportunity to establish a network of health-related contacts
- information on the general situation and health burden of the wounded and the sick
- information on the casualty care chain, including referral systems and contingency plans.

A first aid needs assessment may have a specific objective or it may be part of a general health assessment. In both cases, an assessment examines all stages of the continuum of care for the wounded and the acutely sick. It should:

- estimate the needs (incidents related to the wounded and the sick)
- identify resources available: existing first aid activities, referral possibilities and capacity of key health facilities
- determine if minimum services are available
- determine the unmet needs and priorities of the wounded and the sick
- analyse whether the ICRC should assist the wounded and the sick, and how it should do so.

In areas to which the ICRC has only limited access, it may not be possible to do a 'bird's-eye-view' assessment in the field. A first aid assessment may then have to be based on interviews with key stakeholders, such as; village chiefs; health staff; wounded people; armed and other opposition groups; state forces (the military, security forces, civil-defence personnel, the police, etc.); and other members of the parties to conflict.

Information can also be obtained from referral hospitals and other stakeholders responsible for those working in the area affected. Regular confidential dialogue – between the ICRC and health personnel tending to wounded and acutely sick people – is essential when the ICRC has little or no access. Such dialogue helps to develop a fuller and more reliable picture of existing emergency medical systems and support needs. Such assessment-related confidential dialogue can be undertaken during ICRC assistance activities such as first-aid training for health professionals; provision of emergency medical supplies; or monitoring.

Data from other sources – media reports; reports prepared by other, reliable organizations; and photographs of the area taken by ICRC contacts – can be combined with the data gathered by the ICRC during its interviews. This allows triangulation of information and increases confidence in the reliability of the data.

The ICRC carries out three main types of assessment: rapid, in-depth and continuous. Its choice of assessment will depend on certain factors: the context and its accessibility; the ICRC's objectives; the availability of information from previous assessments; and the time and resources available.

- A **rapid** assessment is always the starting point for establishing or re-establishing ICRC assistance for first aid services; additional information can be added later to complete an in-depth assessment.

- An **in-depth** assessment enables more comprehensive collection of information to support longer-term planning of ICRC support and to assess critical areas identified during a rapid assessment.
- A **continuous** assessment is necessary because conflict situations and emergencies are complex and constantly changing. These assessments help to identify adjustments to first-aid programmes and activities that may be necessary.

An ICRC needs assessment should involve four stages, as shown in the table below. Confirm the level of support the delegation can offer before planning an assessment. The more detailed the information gathered through a thorough assessment, the easier it will be to design, plan and implement a relevant and appropriate first-aid programme.

Conducting an ICRC assessment

Steps	***What has to be done***
1. Purpose	- Define the objectives of the assessment - Determine the type of assessment: rapid, in-depth or continuous - Select the team: personnel from ICRC departments and others
2. Preparation – *Before visit*	- Perform/review/update stakeholder mapping and analysis - Review existing information/data: ICRC and other sources - Decide areas and structures to visit, and key stakeholders to meet - Determine the type of data needed and where/ from whom to get it - Organize data collection - Make logistical and other arrangements for the assessment
3. Information collection – *During visit*	- Document initial observations during visits to the area affected - Meet with stakeholders as arranged or create opportunities for meetings, review all relevant information that may be available at health facilities or other sites of medical care, within communities and among weapon bearers - Visit specific site as planned, including surgical wards, triage areas, morgues, cemeteries and other pertinent areas - Identify and assess existing health surveillance systems - Establish network of key health- and transportation-related contacts
4. Analysis – During and after visit	- Determine urgent needs during visit, including any life-saving assistance that may be required, and provide immediate support (first aid supplies or transportation) - Map services and stakeholder networks - Determine needs and potential ICRC response - Develop recommendations, reporting

The purpose of conducting an assessment for an ICRC first-aid programme may be to:

- learn more about the context
- determine the need for ICRC support
- establish dialogue with contacts
- develop assistance plan for first-aid programmes
- identify or explore possibilities for "vector" activities, which are set up mainly to engage with stakeholders.

Terms of reference (ToR) are developed for each assessment and will describe in detail why the assessment is being done, and where, how and by whom. The ToR should include:

- background information on the situation
- justification for ICRC involvement
- main purpose and objectives of the assessment
- composition of the team and roles and responsibilities.

All delegates should prepare for a needs assessment by reviewing existing information and conducting a stakeholder-mapping exercise.

Stakeholder mapping and analysis: ICRC management may have already conducted stakeholder mapping and analysis, for help in understanding the roles and power of the various actors in the area affected. It is essential to map stakeholders before an assessment; ICRC management's mapping will include weapon bearers, actors involved in health-related matters, and others of pertinence in the area. Stakeholder mapping will be updated after the assessment, and updated also in step with changes in the context. It will assist in planning the assessment; deciding on locations, and on key stakeholders to meet; determining security risks and accessibility of the area.

Reviewing existing information: The information available must be reviewed before going to the area affected. This is helpful for understanding the situation, identifying stakeholders, and determining what information has to be collected. Existing sources of information include literature, websites, databases, reports and maps relating to the area affected.

Sources of valuable and information may include:

- ICRC management team and ICRC departments
- Movement partners: National Societies, IFRC

- UN bodies, including OCHA, UNDSS and WHO
- Donors, embassies
- Defence and health ministries, government departments (i.e. statistical offices)
- Weapon bearers (the websites of some armed groups have casualty reports)
- NGOs, private organizations (i.e. ambulance services) and others involved in providing first aid and health-related assistance in the area.

It might be helpful to meet with senior representatives of the organizations mentioned above – and senior government officials – before visiting the field. This may facilitate access to the area and may also help in setting up meetings with key stakeholders to, for instance, identify key sites such as health facilities under their management. All this may yield additional information, such as:

- assistance policies, activity reports, detailed maps and statistics
- contact details for key figures in the area, such as local authorities, directors of health services, hospital directors, project managers
- overview of the context: demographics, infrastructure and baseline health data
- details about the current situation, security conditions, needs, current response and gaps.

Planning and coordination – in advance, and with all stakeholders – are necessary to reduce risk and prevent problems during the assessment.

Decide what areas – and health and other facilities – to visit, and which key stakeholders to meet: Security conditions and accessibility will determine what areas can be visited for assessment.

The places to visit may include:

- areas reported to be affected by armed conflict or other violence
- areas where, according to stakeholders, unmet needs among the wounded are high
- health facilities in the area affected, particularly facilities treating wounded people
- offices of authorities, military commanders and leaders of armed groups
- offices of those managing or providing assistance to wounded people
- sites where the dead are likely to be found (i.e. graveyards, morgues).

During the stakeholder mapping and analysis, and the review of existing information, it will become evident which key stakeholders should be met. It is advisable to meet authorities first, together with ICRC management, as a mark of respect and to discuss security and access issues. ICRC management can also request the leaders of armed groups to introduce them to the person or persons in charge of health-related matters, so that ICRC health teams can meet with them to discuss the care available to their wounded personnel.

Determine the type of data required and where/from whom to get it: If no previous assessment of the area has been done, it will be necessary to collect information on the general situation as well as on health. This information is also necessary for learning about the services in the area affected and needs among the people affected. However, use of data collected must always be justifiable, and sometimes restricted: this is essential. It is also worth noting that information on the number and types of casualties may be of great value to military intelligence; so be aware of the sensitivity of the data you are collecting.

Data for assessing first aid and related purposes

General and health data

- Security, general context and geographical data
- Demographic data (population, gender, displaced people, vulnerable groups, etc.)
- Health situation:
  - Health ministry policies and procedures (list of essential drugs, treatment protocols)
  - Health-related actors and health facilities in area (functional/non-functional, resources, ambulances, non-governmental)
  - Access to health services (considerations include topography, security conditions, cost)
  - Morbidity and mortality patterns, epidemics
  - Mine-related and other risks
  - Health concerns and priorities of beneficiaries, and health staff and others
  - Pre-hospital set-up (lay and professional response)
- Protection of health care: Incidents affecting provision of care
  - Incidents affecting health workers, and facilities and vehicles used solely for medical purposes
  - Incidents affecting patients and their relatives
  - Management of incidents
- Access for ICRC to area
  - Distance from ICRC delegation/office, state of roads; types of vehicle needed
  - Security and other concerns
  - Communication: Coverage for mobile phones, satellite phone, high-frequency radio

First-aid data

- Medical systems and casualty care chain
  - *Who administers first aid?* National Society volunteers, military medical services, health ministry, untrained weapon bearers, NGOs, private ambulance services
  - *Where do the wounded go?* Types and location of health facilities, and services provided at each stage of the chain (first aid, emergency medical stabilization, wound excision, surgical care)
  - *What capacities are available – at all levels –* to treat wounded people? Staff skills and resources (staff, training, equipment, medical supplies)
  - People who depend on services
  - Transport, evacuation and referral procedures and systems
  - Contingency plans, as well as number and types of incidents and response
  - *How effective or efficient is the casualty care chain*, including evacuation?
- Caseload and epidemiology of the wounded
  - Number of wounded people, number of dead people, main causes of death
  - Types (burns, gunshot), sites (head, limb) and causes of wounds (shell, mine)
  - Origin of wounded people
  - Age, gender
  - *Who is wounded?* Civilians, weapon bearers (police stretcher-bearers, trained soldiers, members of armed groups)
- Unmet needs of wounded people
  - Problems faced by wounded people and actors involved in providing care
  - Incomplete assistance or support provided by other actors
  - Gaps in assistance and plans for support
- Protection of health care:
  - Any arrests of wounded weapon bearers (with possible interruption of health care), or denial of health care to certain wounded people
  - Delayed referral of wounded people (e.g. delays at checkpoints)
  - Denial of access to first-aiders seeking to assist wounded people
  - Lack of respect and protection for first-aiders, stretcher-bearers or other health staff assisting wounded people
  - Awareness: identification used or other preventive measures

5.3 RESULTS, REVIEW AND EVALUATION

The results of the ICRC's first aid activities must be tracked, not only after a meeting or training course, but **mainly after the management of emergency situations**, as that is **the goal of first aid empowerment**. These **outcomes** can be measured at the scene of an emergency. They can also be measured elsewhere: at the home of the wounded and the acutely sick person in question, if they were not in need of further care; at the place to which that person was transported for further care; and/or during debriefing sessions and **lessons learned exercises** with the responders and other stakeholders concerned or involved in the emergency response (e.g. the general population and its leaders).

Lessons learned

The lessons learned analysis should seek **to improve the first aid activities in question – operational or educational – that is, make them stronger, safer and more durable**. Accordingly, the data to be collected, and the overall process, should be simple and easily converted into meaningful and usable information. **Reactions or responses** to this analysis must be provided without undue delay (shortly after the activity undertaken or the collection of data). Those at the receiving end include the following: people directly involved in the activity or data collection; people required to respect the casualties; people involved in ensuring respect and providing support for casualties; and the emergency-care responders and first-aiders concerned. The purpose is to consolidate the motivation and the assets, and to help to tackle doubts, concerns and deficiencies. Evidence of success or failure – and the reasons for either – should be presented and discussed.

The most important matters to assess in the lessons learned process are:

- related to the primary goal: lives saved and suffering alleviated, and the results of the care provided along the casualty care chain
- the possible effects among the following:
  - weapon bearers and people likely to be present at the scene of an emergency: their resilience, their involvement and participation in the response to emergencies, their trust in emergency-care responders, their acceptance of that particular National Society, etc.
  - emergency-care responders: their confidence and motivation, their performance, their well-being, how they value the support offered, etc.

- humanitarian assistance: readier access to people in need and to referral facilities, greater respect for the red cross, red crescent and red crystal emblems and for the provision of health care, etc.
- National Societies and other organizations receiving support: e.g. improvement in structure, functioning; coordination and collaboration; greater acceptance; broader access to people in need; expanded emergency-response capacities.

For programmes that are remotely delivered and monitored – currently the main operational model for ICRC first-aid programmes in high-conflict areas – **qualitative information** from various sources[18] is a necessity. Data of this kind are useful for evaluating the relevance of a programme when direct supervision, and conventional quantitative monitoring and evaluation, is not possible (or reliable). Collecting qualitative data should be possible in most places if done after securing the necessary consent or in a non-interrogative manner during meetings or tours. Some interviewees may be unwilling to part with such information because they regard it as sensitive and potentially damaging (e.g. weapon bearers often consider such information to be valuable military intelligence, and local health authorities may not want to have any attention drawn to their shortcomings).

As for monitoring and evaluating first aid activities (operational and educational), a **baseline** must be established before the delivery of support, with simple and meaningful indicators, and during the first stage of implementation of first aid support if it was not done during the assessment phase.

18 Triangulation of testimonies, public-services data, media reports, interviews, etc.

6. FINAL NOTE

This document is an **overview only of the first-aid training programme, its components and beneficiaries** (population affected/wounded or sick people are *direct* beneficiaries; emergency-care responders/care providers are *indirect* beneficiaries), and can serve as a brief guide to consult before developing and implementing first aid training activities. Programmes and projects have the best chance to be effective, efficient and collaborative when their development is preceded by a detailed needs assessment and when they follow a results-based approach.

The first-aid coordination team at ICRC headquarters can provide specific technical guidance for programme development, advice on the availability of human resources (i.e. first-aid delegates, first aid specialists, first-aid field officers, etc.) or contacts at concurrent projects in similar contexts or locations. It is important to consult the first-aid team at ICRC headquarters before implementing any of the components of a first aid training programme or developing an first aid project of any kind — to ensure that delegations and populations affected can benefit from all the expertise and experience that is available.

The ICRC helps people around the world affected by armed conflict and other violence, doing everything it can to protect their lives and dignity and to relieve their suffering, often with its Red Cross and Red Crescent partners. The organization also seeks to prevent hardship by promoting and strengthening humanitarian law and championing universal humanitarian principles.

People know they can count on the ICRC to carry out a range of life-saving activities in conflict zones and to work closely with the communities there to understand and meet their needs. The organization's experience and expertise enables it to respond quickly and effectively, without taking sides.

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