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Professional Standards and Legal Standard Setting

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Professional Standards and Legal Standard Setting: INSARAG, FMTs, and International Disaster Relief Volunteers

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ABSTRACT

This Article draws attention to the nascent efforts of emergency medical personnel, convened under World Health Organization auspices, to improve humanitarian health responses following catastrophic natural disasters. The Foreign Medical Team Working Group (FMT-WG) is pursuing new professional standards related to sectoral coordination, classification and registration. As its approach has been significantly influenced by the International Search and Rescue Advisory Group's (INSARAG) prior advances in these areas, INSARAG's contributions will first be highlighted. While more atypical contributors to international lawmaking than traditionally studied, the efforts by both groups shed significant light into the burgeoning International Disaster Response Law field. Two principle assertions here: that soft law-oriented technical guidelines can address highly time-sensitive, operational challenges related to transnational relief; and that ongoing professional self-regulation within specific response sectors may bolster state willingness to open its borders to outside international relief, even in the absence of a formal convention to do so.

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"They didn't bring much with them. They didn't bring any supplies, they didn't bring water. They didn't bring food . . . They thought that shelter would be provided – that all they had to do was show up and say, 'I'm a doctor, where can I do surgery?' And it doesn't work like that."¹

I. INTRODUCTION

Over the past fifteen years, a new field known as International Disaster Response Law (IDRL) has emerged, seeking to address some of the most pressing challenges related to cross-border relief following natural disasters. Field literature highlights IDRL's marked paucity of hard-law frameworks compared to other more established areas of public international law, and its alternatively pronounced soft character.² In addition to public, state-generated declarations, resolutions, and other non-binding instruments, IDRL's soft-law nucleus also embodies sector-based, highly technical professional codes of conduct, handbooks, and guidelines. Yet scholars pay little notice to the various agents of these professional guidelines and standards and the respective strategies they have employed to ameliorate the sundry issues pertaining to international disaster response while enhancing international law in the process.

This study draws attention to the nascent efforts of emergency medical personnel, convened under the auspices of the World Health Organization's Global Health Cluster, to improve humanitarian health responses following sudden onset natural disasters. The

1. Amy Costello, *Medical Volunteers Learn From Mistakes Made in Rush to Haiti*, PUB. RADIO INT'L (Oct. 12, 2012, 1:25 PM), <http://www.pri.org/stories/2012-10-12/medical-volunteers-learn-mistakes-made-rush-haiti> [http://perma.cc/9W56-BDZC] (archived Sept. 22, 2015).

2. INT'L FED'N OF RED CROSS & RED CRESCENT SOCIETIES, LAW AND LEGAL ISSUES IN INTERNATIONAL DISASTER RESPONSE: A DESK STUDY 15 (2007) [hereinafter IFRC DESK STUDY]; Andrea de Guttry, *Surveying the Law*, in INTERNATIONAL DISASTER RESPONSE LAW 3, 36 (Andrea de Guttry et al. eds., 2012).

Foreign Medical Team (FMT) Working Group is targeting several problem areas by formulating operational guidelines related to FMT coordination, classification, and registration. However, these strategies are not exclusive to the emergency medical sector. Urban search and rescue (USAR) practitioners, under the aegis of the International Search and Rescue Advisory Group (INSARAG), were the first in the entirety of the international humanitarian system to devise protocols of this nature, dating back to 1991.³ The FMT Working Group participants openly acknowledge the strong influence of INSARAG's approach and experience in shaping their own policy proposals. Accordingly, a preliminary examination of INSARAG's efforts will also be provided for contextual purposes.

While a twenty-year span separates the launches of the INSARAG and FMT initiatives, it will be shown that both address essentially the same operational challenge—bringing a semblance of order and professionalism to the chaos-prone universe of large-scale, cross-border humanitarian aid following catastrophic natural disasters. The quest for professionalism within the larger system is a central concern across the discipline, even for mainstay humanitarian relief actors.⁴ The added convergence of spontaneous, unaffiliated volunteers from across the globe at the disaster site—a common phenomenon to be introduced at the beginning of this study—further complicates matters greatly.

Health professionals and urban search and rescue personnel represent epistemic communities of highly specialized expertise. These groups are more atypical contributors to international lawmaking than traditionally studied. Yet their efforts shed light into the IDRL field in myriad ways. Two principle assertions will be highlighted here: that soft-law-oriented technical guidelines can address highly time-sensitive, operational challenges faced by responding and disaster-affected states related to transnational relief; and that ongoing professional self-regulation within specific disaster response sectors may bolster state confidence—and therefore its willingness—to open its borders to outside international relief in the future, even in the absence of a formal convention to do so.

3. See Office of the U.N. Disaster Relief Coordinator (UNDRO), *Inaugural Meeting of the International Search and Rescue Advisory Committee (INSARAC)*, at 1–8 (Dec. 11–13, 1991), http://www.insarag.org/images/stories/Documents/Steering_Group/1991_INSARAC_Inaugural_Meeting_Documentation.pdf. [<http://perma.cc/HP76-67E5>] (archived Sept. 22, 2015).

4. See PETER WALKER & CATHERINE RUSS, *PROFESSIONALISING THE HUMANITARIAN SECTOR: A SCOPING STUDY, ENHANCED LEARNING & RESEARCH FOR HUMANITARIAN ASSISTANCE 3* (2010), http://www.elrha.org/wpcontent/uploads/2015/01/Professionalising_the_humanitarian_sector.pdf [<http://perma.cc/EUN5-ALVC>] (archived Sept. 22, 2015) (reviewing the current state of professionalism in the humanitarian sector).

II. PART OF THE CURE BUT ALSO PART OF THE PROBLEM? “THE EPIC MEGA-DISASTER,” CONVERGENCE, AND INTERNATIONAL DISASTER RESPONSE LAW

While disasters assume many forms—ranging from armed conflict to the technological—sudden onset events caused by natural hazards—including earthquakes, tsunamis, and typhoons—tend to trigger a distinctive brand of international aid response not experienced elsewhere in the humanitarian relief system. Their unexpected nature and rapidly unfolding timescale generate a global burst of public attention, far greater than slow onset natural crises such as droughts or conflict-based humanitarian emergencies, both of which may play out over years, if not decades. Rapid onset tragedies stemming from the physical environment also tend to be more “media-friendly” in that their causes are more easily grasped by news consumers and the events typically produce attendant powerful visual images.⁵ Further, there may even be an innate bias, resulting in the public perception that the victims of natural disasters are less at fault for their plight compared to those caught up in violence.⁶

Commentators have lamented the pattern of an imbalanced media coverage in favor of more dramatic natural disasters rather than crises with more complex origins. The International Federation of the Red Cross’s 2005 *World Disasters Report* expressed its frustration regarding the greater media appeal of the 2004 Indian Ocean Tsunami compared to other concurrent but underreported humanitarian crises:

Disasters that are unusual yet explicable, and that cause considerable death or destruction in accessible places which the audience is believed to care about, get covered. Baffling stories get less attention . . . Today, TV news is part news and part entertainment. So it’s understandable that sudden, dramatic disasters like volcanoes or tsunamis are intensely newsworthy, whereas long-drawn-out crises (difficult to describe, let alone film) are not.⁷

Sudden onset events with significantly high death tolls and destruction, or what the International Red Cross Federation’s

5. See ACTIVE LEARNING NETWORK FOR ACCOUNTABILITY & PERFORMANCE IN HUMANITARIAN ACTION [ALNAP], “DON’T CHASE HEADLINES, CHASE GOOD QUALITY NEWS . . . DON’T BE FIRST, BE ACCOUNTABLE”: A NEW AGENDA FOR NEWS MEDIA AND HUMANITARIAN AID 7–11 (2008), <http://www.alnap.org/resource/5057> [<http://perma.cc/EL5P-S3DA>] (archived Sept. 22, 2015).

6. Hanna Zagefka et al., *Donating to Disaster Victims: Responses to Natural and Humanly Caused Events*, 41 EUR. J. SOC. PSYCHOL. 361–62 (2011).

7. INT’L FED’N OF RED CROSS & RED CRESCENT SOCIETIES, *Humanitarian Media Coverage in the Digital Age*, in WORLD DISASTERS REPORT (2005), <http://www.ifrc.org/en/publications-and-reports/world-disasters-report/wdr2005/wdr-2005--chapter-6-humanitarian-media-coverage-in-the-digital-age/> [<http://perma.cc/XK E9-RH5N>] (archived Sept. 22, 2015).

Malcolm Lucard termed the “epic mega-disasters,” especially draw media notice.⁸ While small and medium size disasters are far more common and cumulatively cost far more loss of life, it is the single, highly deadly, catastrophic case—such as the 2004 Indian Ocean Tsunami, the 2010 Haiti Earthquake, or Typhoon Haiyan that struck the Philippines in 2013—that garner the lion’s share of global media interest.⁹ Moreover, in the past decade, grassroots social media have served to further draw the world’s attention to specific episodes. Photos, amateur videos, and emails circulated worldwide by Europeans vacationing in tsunami-devastated areas in December 2004 signified a major turning point in citizen coverage of disasters in the digital age; by the time of the 2010 Haitian quake, social media technology such as Twitter, Facebook, and the crowdsourcing platform Ushahidi were widespread and fundamentally shaping the global public’s understanding of unfolding events.¹⁰

Regular, full-time international humanitarian practitioners, including those associated with UN agencies and the major nongovernmental relief organizations such as Doctors Without Borders, CARE, and OXFAM, are guided by a professional, needs-based ethic, responding regardless of whether the popular news outlets are paying attention or not. However, after extraordinary, nature-based tragedies such as a devastating earthquake or hurricane, these professional humanitarians suddenly find themselves joined by a momentous flood of thousands of volunteers similarly desiring to help. Recognized for decades in disaster management circles as the process of “external convergence,” the impacted area is barraged by outside goods and materials (material

8. Malcolm Lucard, *Out of Sight, Out of Mind*, MAG. INT’L RED CROSS & RED CRESCENT MOVEMENT, 2011, at 2, http://www.redcross.int/EN/mag/magazine2011_2/18-23.html [<http://perma.cc/4DES-ZGS4>] (archived Sept. 22, 2015).

9. See Yan Yan & Kim Bissell, *The Sky Is Falling: Predictors of News Coverage of Natural Disasters Worldwide*, COMM. RESEARCH, Feb. 27, 2015, at 1 (discussing the media’s disproportionate favor of major versus small natural disasters).

10. See GLENDA COOPER, FROM THEIR OWN CORRESPONDENT? NEW MEDIA AND THE CHANGES IN DISASTER COVERAGE: LESSONS TO BE LEARNT 5 (2011), http://reutersinstitute.politics.ox.ac.uk/sites/default/files/From%20Their%20Own%20Correspondent_0.pdf [<http://perma.cc/DS9C-ZTGA>] (archived Sept. 22, 2015) (describing aid workers’ use of the power of social media to raise awareness and funds in Haiti); Steve Outing, *Taking Tsunami Coverage into their Own Hands*, POYNTER (Jan. 6, 2005, 1:55 AM), <http://www.poynter.org/uncategorized/29330/taking-tsunami-coverage-into-their-own-hands/> [<http://perma.cc/JG4X-97XT>] (archived Sept. 22, 2015) (“[T]he 2004 tsunamis represent the point at which a major change takes place in the media world.”); ALEKSANDRA SARCEVIC ET AL., “BEACONS OF HOPE” IN DECENTRALIZED COORDINATION: LEARNING FROM ON-THE-GROUND MEDICAL TWITTERERS DURING THE 2010 HAITI EARTHQUAKE 47–56 (2012), http://www.cs.colorado.edu/users/palen/Home/Crisis_Informatics_files/Sarcevic-et-al-HaitiMedicalTwitterers_1.pdf [<http://perma.cc/4NM4-R25S>] (archived Sept. 26, 2015) (exploring the role of Twitter in medical coordination during the disaster response following the Haiti earthquake).

convergence), informational inquiries and offers of assistance (informational convergence), and a significant influx of people (physical convergence). The latter are motivated by a range of impulses, from a genuine wish to assist to disaster voyeurism.¹¹

One category of volunteer who participates is part of an outer ring of the more institutionalized humanitarian system, affiliated with mainstay volunteer organizations such as the International Federation of the Red Cross/Red Crescent¹² or part of an on-call roster by national governments.¹³ Most in this volunteer subset will have, at a minimum, training in the international disaster response field and may further possess prior experience serving in such contexts. Far more problematic, however, are arrivals who are unattached to any disaster response organization or framework, whether national or international. This group is referred to as the “spontaneous” or “unaffiliated” volunteer, a phenomena common both within solely domestic disasters (September 11th being a particularly notable case)¹⁴ as well as those that spark a significant international response. This volunteer type may have no directly relevant skill sets but still want to help by serving as drivers or by providing other basic services. Alternatively, they may be professionals in their respective fields at home, such as an emergency room nurse or a trauma surgeon. The latter category may have offered their services to one of the major humanitarian NGOs, but were rejected due to their lack of international experience. These individuals instead choose to “self-deploy.”¹⁵ In extreme cases, they may be imposters who falsely indicate they are professionally credentialed.

11. See generally CHARLES E. FRITZ & J.H. MATHEWSON, CONVERGENCE BEHAVIOR IN DISASTERS: A PROBLEM IN SOCIAL CONTROL 29-60 (1957), <https://ia800304.us.archive.org/10/items/convergencebehav00fritrich/convergencebehav00fritrich.pdf> [<https://perma.cc/ZCW4-XZ5Z>] (archived Sept. 22, 2015) (discussing the broad range of factors motivating convergence behavior).

12. For a sample statement regarding the preference to have disaster relief volunteers participate within the organized humanitarian network, please refer to the United States Agency for International Development’s Center for International Disaster Information FAQ page at: <http://www.cidi.org/how-disaster-relief-works/faqs/#hideslide8p49> [<http://perma.cc/5KWM-J7NY>] (archived Oct. 11, 2015). A list of relevant U.S. organizations working in this space is located on the InterAction website: http://www.interaction.org/member-directory?keywords=&field_issue_area_tid%5B%5D=1239 [<http://perma.cc/Z99S-V5FR>] (archived Oct. 11, 2015).

13. DAMON COPPOLA, INTRODUCTION TO INTERNATIONAL DISASTER MANAGEMENT 496-498 (2015).

14. See Seana Lowe & Alice Fothergill, *A Need to Help: Emergent Volunteer Behavior after September 11th*, in BEYOND SEPTEMBER 11TH: AN ACCOUNT OF POST-DISASTER RESEARCH 293, 294, 296-310 (2003); Lauren S. Fernandez et al., *Spontaneous Volunteer Response to Disasters: The Benefits and Consequences of Good Intentions*, 4 J. EMERGENCY MGMT. 57, 57 (2006) (describing one type of volunteer as “volunteers on an assigned resource”).

15. See Joshua Whittaker et al., *A Review of Informal Volunteerism in Emergencies and Disasters: Definition, Opportunities and Challenges*, 13 INT’L J.

While there are thousands of examples of spontaneous, unattached volunteers rushing to disaster-impacted countries, the following excerpt from a *Time* magazine employee's diary blog captures the movement perfectly. The blog author, Lonny Vargas, a production manager at the magazine, decided to personally respond to the 2010 Haiti disaster, along with eleven fellow church members, including "a restaurant manager, a school principal, an accountant, a flight attendant and a truck driver."¹⁶ Vargas describes both the impact of news coverage upon his impulsive decision to go to Haiti as well as his personal recruitment of other spontaneous volunteers:

The news of the earthquake shook me to the core. I thought of the children without parents, the parents who lost their children. The elderly, and the sick. How could I sit do nothing? I wanted to put legs on my faith, and do something for these people. When I got to work, I sent an email to about 15 guys asking if they wanted to try to get in and help. About half a dozen guys immediately expressed interest. Now, none of us knew anything about Haiti other than where it was on a map. But one of our guys managed to find a contact at a small missions fellowship in Barahona, Dominican Republic — 1.5 hours from the Haitian border. By the time I called the number and talked to Lewis, our team was up to 12—as it happens, the exact number Lewis could accommodate.¹⁷

Thousands of doctors and nurses also came forward from around the globe to participate in the Haiti response. Two-thirds of the surgeons who volunteered from the United States had never participated before in disaster relief.¹⁸ In another anecdotal example, Andy Day, an anesthesiologist, and his wife, Jennifer Day, a nurse, volunteered to assist in Haiti after watching a charity telethon, though neither had ever worked at a hospital outside of the United States.¹⁹ The Indiana couple's motivation to help was again spurred by the images coming out of Haiti: "[W]hat really caught the couple's attention were the pictures of the kids—bandaged and bleeding, missing limbs. The Days decided they could not sit by as mere

DISASTER RISK REDUCTION 358 (2015), <http://www.sciencedirect.com/science/article/pii/S2212420915300388> [<http://perma.cc/D3EJ-VGKA>] (archived Oct. 11, 2015); Mary Merrill, *The New Unaffiliated Volunteers*, WORLD VOLUNTEER WEB (Mar. 22, 2005), at 1–2, <http://www.worldvolunteerweb.org/news-views/viewpoints/doc/the-new-unaffiliated-volunteers.html> [<http://perma.cc/T76H-E268>] (archived Sept. 22, 2015) (discussing volunteers turned down by international agencies who then take matters into their own hands to volunteer how, when, and where they want).

16. Deirdre Van Dyk, *Introduction, Out of Faith and Compassion: Diary of a Haiti Volunteer*, TIME (Jan. 30, 2010), http://content.time.com/time/specials/packages/article/0,28804,1953379_1953494_1957869,00.html [<http://perma.cc/B7RX-4Z7S>] (archived Sept. 22, 2015).

17. Lonny Vargas, *Out of Faith and Compassion: Diary of a Haiti Volunteer*, TIME (Jan. 30, 2010), at 1, http://content.time.com/time/specials/packages/article/0,28804,1953379_1953494_1957869,00.html [<http://perma.cc/3FRF-4Z67>] (archived Sept. 22, 2015).

18. Costello, *supra* note 1, at 4.

19. *Id.* at 1–2.

observers of the suffering. Before they knew it Andy and Jennifer landed in Port-au-Prince. Almost immediately, Jennifer had second thoughts." Later when the Days were asked about which organization they were affiliated with, Andy Day had to reply that: "There wasn't a name. It was a friend of a friend."²⁰

The challenges posed by the incoming flood of spontaneous volunteers to the disaster site are wide-ranging and well-documented, not only in relation to Haiti and other mega disasters, including the 2004 Tsunami, but in most major natural disasters going back to the 1980s, as will be shown shortly with INSARAG. Their arrival sets off a chain of complications for the relief effort, some even deadly. International disaster response, even when limited to professional networks, is a massively human-intensive operation. A further flood of unexpected volunteers creates an immense aid bottleneck at border entry points into the stricken state. Many unaffiliated volunteers arrive without self-sufficiency and proper vaccinations for endemic diseases, further burdening an already stressed local response capacity and draining supplies from international providers meant for the local victims of the crisis.²¹ Many come without language skills or any familiarity with the country's culture.²² They may misrepresent credentials or have ones ill-suited to international emergency contexts, causing additional suffering and physical harm to the victims.²³ Volunteers also raise significant issues regarding

20. *Id.* at 7; see also Patrick Barta, *Dropping Everything*, WALL ST. J., Sept. 17, 2005, at 1–2, <http://www.wsj.com/articles/SB112691877231043862> [<http://perma.cc/PMM5-UB8U>] (archived Sept. 22, 2015) (detailing the work of an unattached volunteer in Sri Lanka after the tsunami); David Montero, *US Volunteers Find Pakistan More Friendly Than Feared*, CHRISTIAN SCI. MONITOR, Nov. 23, 2005, at 2–3, <http://www.csmonitor.com/2005/1123/p01s01-wosc.html> [<http://perma.cc/D9CT-AHCU>] (archived Sept. 22, 2015) (discussing the work of both affiliated and unattached volunteers in Pakistan).

21. See JoNel Aleccia, *Disaster Do-Gooders Can Actually Hinder Help*, NBCNEWS.COM (Jan. 23, 2010), http://www.nbcnews.com/id/34958965/ns/world_news-haiti/t/disaster-do-gooders-can-actually-hinder-help/#.VVyRipXbKM8 [<http://perma.cc/PD7Y-XFAG>] (archived Sept. 22, 2015).

22. See *id.*

23. See Raina M. Merchant et al., *Health Care Volunteers and Disaster Response—First, Be Prepared*, 362 NEW ENG. J. MED. 872, 872–73 (2010); Daniël J. Van Hoving et al., *Haiti Disaster Tourism—A Medical Shame*, 25 PREHOSPITAL & DISASTER MED. 201, 202 (2010); Aleccia, *supra* note 21, at 1–2; Jamie Aten, *How Churches Can Help Without Hurting After Super Typhoon Haiyan*, CHRISTIANITY TODAY (Nov. 8, 2013), <http://www.christianitytoday.com/ct/2013/november-web-only/how-to-help-after-super-typhoon-haiyan.html> [<http://perma.cc/5G36-4AMF>] (archived Sept. 22, 2015); Barta, *supra* note 19; Costello, *supra* note 1, at 4–7; William Weir, *Disaster Tourists: Volunteers Advised to be with a Group, or They May Get in the Way*, HARTFORD COURANT (Sept. 12, 2005), http://articles.courant.com/2005-09-12/features/0509100243_1_disaster-team-relief-effort-disaster-sites [<http://perma.cc/DTU3-QYMM>] (archived Sept. 22, 2015).

liability, insurance coverage, and other major points of domestic law.²⁴

There have been significant and multifaceted reform initiatives pertaining to the provision of international relief over the past twenty-five years, as well as attendant efforts to organize and strengthen national and international legal frameworks related to disaster response. The United Nations, where much of international humanitarian assistance coordination is nested, has come a long way since the landmark passage of UNGA Resolution 46/182: "Resolution on strengthening of the coordination of emergency humanitarian assistance of the United Nations," which marked a sharp operational and organizational departure for the world body. Passed in December 1991, 46/182, along with a major set of further reforms undertaken in 2005, have led to the creation of many of the relief mechanisms associated with the United Nations today including the Department of Humanitarian Affairs (later United Nations Office for the Coordination of Humanitarian Affairs or UNOCHA), the position of the Emergency Relief Coordinator (ERC), the Inter-Agency Standing Committee (IASC), the Central Emergency Response Fund (CERF), the Consolidated Appeals Process (CAP), and the Cluster Approach, establishing sectoral leadership during relief efforts.²⁵ On the NGO side of the international humanitarian equation, there have also been several substantive ventures related to professional quality standard-setting among the major nongovernmental providers, including, principally among them (by the year they were introduced), *Code of Conduct for the International Red Cross and Red Crescent Movement and non-governmental organizations (NGOs) in disaster relief* (1994), *People in Aid's Code of Best Practice* (1997), the *Sphere Standards* (1999) and its most recent iteration *Core Humanitarian Standard on Quality and Accountability* (2014), and the Humanitarian Accountability Project (HAP) *International Standards* (2005).²⁶

24. See INT'L FED'N OF RED CROSS & RED CRESCENT SOCIETIES, THE LEGAL FRAMEWORK FOR VOLUNTEERING IN EMERGENCIES 29–54 (2011), <http://www.ifrc.org/PageFiles/125640/legalframework.pdf> [<http://perma.cc/HY2H-9RF6>] (archived Sept. 22, 2015) (discussing liability issues that often arise in the emergency volunteer context and legislation enacted addressing this liability); Sharif Elgafi, *Medical Liability in Humanitarian Missions*, J. HUMANITARIAN ASSISTANCE 3–6 (2014), <https://sites.tufts.edu/jha/archives/2111> [<https://perma.cc/GUE9-HN4J>] (archived Sept. 22, 2015).

25. Andrej Zwitter, *United Nations' Legal Framework of Humanitarian Assistance*, in INTERNATIONAL LAW AND HUMANITARIAN ASSISTANCE: A CROSSCUT THROUGH LEGAL ISSUES PERTAINING TO HUMANITARIANISM 51, 51, 55–60 (Hans-Joachim Heintze et al. eds., 2011); PETER WALKER & DANIEL MAXWELL, SHAPING THE HUMANITARIAN WORLD 104–08 (Thomas G. Weiss et al. eds., 2009).

26. See WALKER & MAXWELL, *supra* note 25, at 129–35; JOHN COSGRAVE, JOINT STANDARDS INITIATIVE, HUMANITARIAN STANDARDS—TOO MUCH OF A GOOD THING? 1–2 (2013), <http://pool.fruitycms.com/humanitarianstandards/Humanitarian->

While these undertakings by the United Nations and the leading relief NGOs have incrementally improved disaster relief within the established networks of humanitarian providers (although that still remains a work in progress), neither of these directly address the issue of converging unaffiliated volunteers and the quality challenges they may pose. IDRL, a field barely into its third decade, is currently engaging in a delicate balancing act on this issue in several directions. On the surface, the legal framework appears up to the task; through the exercise of their sovereignty, states can determine who enters their country via the enforcement of visa regulations, licensure, and other domestic regulations for personnel crossing their borders. Yet, for numerous reasons, particularly in the wake of natural disasters, many governments are not in a position to appropriately manage a significant inflow of external actors. Coordination in every direction is a struggle as De Siervo writes:

The national institutions in charge of coordinating post-disaster operations usually have to deal with a very challenging environment; infrastructures are often seriously damaged; coordinators are often personally affected by the event; the high pressure by the public opinion and the media is constant. Moreover, authorities usually have limited knowledge and understanding of the complexity, culture, policies, procedures, and working mechanisms of international relief organizations, and vice versa.²⁷

In such circumstances, states may not consistently enforce or may waive their rules altogether governing entry and credentials.²⁸

To date, the significant concerns of the international humanitarian community have actually been in the opposite direction. For example, host states' overly restrictive laws and bureaucratic processes impede or block the entrance of relief workers into the impacted country. Further, few domestic frameworks are in place for expedited recognition of foreign professional credentials during times of emergencies.²⁹ These concerns were actually the genesis of the *Guidelines for the domestic facilitation and regulation of international disaster relief and initial recovery assistance* adopted by the International Conference of the Red Cross and Red Crescent in 2007, which is considered to be the international model for ideal practices in this area.³⁰ However, the Federation also recognizes that

standards-too-much-of-a-good-thing-John-Cosgrave-Feb-2013.pdf [http://perma.cc/BP7Y-SCWX] (archived Sept. 22, 2015).

27. Giovanni De Siervo, *Actors, Activities, and Coordination in Emergencies*, in INTERNATIONAL DISASTER RESPONSE LAW 485, 488–89 (Andrea de Guttry et al. eds., 2012).

28. IFRC DESK STUDY, *supra* note 2, at 119.

29. Stefano Silingardi, *The Status of Emergency Workers*, in INTERNATIONAL DISASTER RESPONSE LAW 551, 559–69 (Andrea de Guttry et al. eds., 2012); IFRC DESK STUDY, *supra* note 2, at 118.

30. INT'L FED'N OF RED CROSS & RED CRESCENT SOCIETIES, INTRODUCTION TO THE GUIDELINES FOR THE DOMESTIC FACILITATION AND REGULATION OF INTERNATIONAL

too much looking the other way by the state involved in a national disaster invites its own share of risks, as IFRC's defining desk study on IDRL explains: "For affected persons, a lack of effective control, particularly over medical services, raises an elevated potential for sub-standard assistance. For example, after the 2004 tsunami, teams of Scientologists responded in Sri Lanka, Indonesia and India to perform their modern version of faith healing on affected persons."³¹

Developing an approach that simultaneously addressed concerns with professional standards and built trust with disaster-impacted states pertaining to cross-border assistance came from a highly surprising corner of the international humanitarian community. USAR personnel were the first to develop what ultimately became a sophisticated set of sector-based protocols that would ultimately be globally endorsed by states via the UN General Assembly and become a model for other providers regarding the professionalization of international relief. As will be shown, it was not a process that happened overnight, but efforts by what ultimately became known as the International Search and Rescue Advisory Group built a strong scaffolding upon which the humanitarian health sector could recently begin to fashion a remedy for the plethora of issues within its own community.

III. PROFESSIONALIZING INTERNATIONAL VOLUNTEER RESPONSE: THE "INSARAG MODEL"

INSARAG's origins date back to the 1980s, with the dawning of the mass casualty age due to high-rise building collapse. Worldwide, growing urbanization coupled with a massive construction surge led to the appearance of high occupancy dwellings frequently comprised of seismically vulnerable pre-cast concrete.³² Further, construction standards in the Global South, where many megacities began emerging, were often undermined by cheap building materials, weak government regulation, and marked corruption.³³

Together, the catastrophic 1985 Mexico City and 1988 Soviet Armenia earthquakes exhibited this emerging new reality of human vulnerability. They also demonstrated the total absence of domestic or international response capacity specifically designed to rescue

DISASTER RELIEF AND INITIAL RECOVERY ASSISTANCE 8 (2011), [http://www.ifrc.org/PageFiles/41203/1205600-IDRL%20Guidelines-EN-LR%20\(2\).pdf](http://www.ifrc.org/PageFiles/41203/1205600-IDRL%20Guidelines-EN-LR%20(2).pdf) [<http://perma.cc/C2HG-QY96>] (archived Sept. 22, 2015).

31. IFRC DESK STUDY, *supra* note 2, at 119.

32. See ROBERT RHEA & BRIAN ROUSSEAU, FUNDAMENTALS OF TECHNICAL RESCUE 131–34 (2009).

33. See Andrew C. Revkin, *Disaster Awaits Cities in Earthquake Zones*, N.Y. TIMES (Feb. 25, 2010), <http://www.nytimes.com/2010/02/25/science/earth/25quake.html?pagewanted=all> [<http://perma.cc/9CEM-N3Z3>] (archived Sept. 22, 2015).

individuals caught in building collapses.³⁴ At the same time, the rise of cable television news drew instant global attention to both events, producing a strong international audience interest in disaster coverage.³⁵

Galvanized by the powerful visuals coming out of both events, individuals with varying levels and forms of search and rescue experience began to converge upon the devastated areas. With no formal intake procedures at points of entry, it is estimated that volunteers from nine countries ultimately deployed to Mexico, including a mix of personnel from local fire services, national military units, and citizen search dog groups as well as specialists from the private sector, each with their own variations of training, equipment, and technologies.³⁶ The United States, for instance, sent regular firefighters and paramedics, but also U.S. Forest Service fire response units, mining search and rescue personnel, heavy demolition workers and private search dog teams.³⁷ Many international teams did not arrive until almost fifty-six hours after the quake had struck.³⁸ Beyond deployment challenges, more vital hours were lost due to the total confusion as to which sites had been searched, heated on-site arguments between national teams regarding protocols and strategies, communications challenges, training differences, and insufficient equipment.³⁹ The disarray repeated itself in Armenia three years later, with international USAR teams continuing to

34. For a detailed treatment of the rise of international urban search and rescue in relation to the Mexico City and Armenia earthquakes, see Kirsten Nakjavani Bookmiller, *The International Law of 96 Hours: Urban Search and Rescue Teams and the Current State of International Disaster Response Law*, in *THE INTERNATIONAL LAW OF DISASTER RELIEF* 111, 115–121 (David Caron et al. eds., 2014).

35. See Michael J. Robinson, *Two Decades of American News Preferences, Part 2: News Interest Across Decades and "News Eras"*, PEW RESEARCH CTR. FOR THE PEOPLE & THE PRESS, Aug. 22, 2007, at 5, <http://www.pewresearch.org/files/old-assets/pdf/NewsInterest1986-2007Part2.pdf> [<http://perma.cc/8ZD5-LFG9>] (archived Sept. 22, 2015).

36. Louise K. Comfort, *International Disaster Assistance in the Mexico City Earthquake*, FMHI PUBS., 1986, at 15–16; see also Lionel Barber, *World Ready to Help If Mexico Makes Request: 'Let's Assess the Need,' Envoy Says*, WASH. POST, Sept. 21, 1985, at A18; Edward Cody, *Rescue Workers Dig for Quake Survivors*, WASH. POST, Sept. 22, 1985, at A1; Paul Knox, *Mexican President Faces Criticism as Rescue Teams Race Against Time*, GLOBE & MAIL (Toronto), Dec. 23, 1985, at 1–2.

37. George Lardner, Jr., *Donations to Agencies Favored in Quake Relief: Halt to Gifts of Food and Clothing Urged*, WASH. POST, Sept. 22, 1985, at A18; see also U.S. EMBASSY-MEXICO CITY, FINAL DISASTER SUMMARY REPORT MEXICO—1985 EARTHQUAKE 27 (1986).

38. Comfort, *supra* note 36, at 23.

39. See E.L. QUARANTELLI, UNIV. OF DEL. RESEARCH CTR., ORGANIZATIONAL RESPONSE TO THE MEXICO CITY EARTHQUAKE OF 1985: CHARACTERISTICS AND IMPLICATIONS 10 (1992); Paul Knox, *Canadian Rescuers Thwarted in Bid to Find Victims*, GLOBE & MAIL (Toronto), Sept. 25, 1985, at 1; Paul Knox, *Hopes Fade for Survivors in Mexico's Quake Chaos*, GLOBE & MAIL (Toronto), Sept. 25, 1985, at 3.

arrive far outside the survivability window with wildly uneven levels of training and no cross-team cooperation.⁴⁰ Concluding that external search and rescue teams were responsible for less than 1 percent of live rescues during the Armenian disaster,⁴¹ the sector was urged to take action.⁴² In 1989, UNDRO convened an inaugural meeting of national emergency managers and diplomats in Geneva to examine nine problematic areas of international disaster relief, with search and rescue activities included among them.⁴³

Out of this gathering would ultimately emerge INSARAG, a transgovernmental network of subnational and national emergency management practitioners, currently headquartered in the Emergency Services Branch of UNOCHA in Geneva.

Under UN auspices, INSARAG has, since its inception, sought to strengthen coordination and standardization among internationally certified teams, reduce the number of volunteers without appropriate training or credentials and build international community confidence that external USAR is a value-added resource worthy of supporting. The group has achieved these interrelated goals with a multidimensional strategy. In addition to the creation of the On-Site Operations Coordination Center, which will be discussed in tandem with INSARAG's classification process below, another track has been the drafting and ongoing revision of the INSARAG Guidelines and Methodology. First endorsed in June 1999 as the "International Search and Rescue Guidelines" (ISARR),⁴⁴ the document is a living handbook for the transnational USAR community and sending and host governments. It is dedicated to establishing a common term of reference for international responders, whose primary job is to work in national search and rescue contexts.⁴⁵ The latest revision was

40. Charles Krimgold, *Search and Rescue*, 5 EARTHQUAKE SPECTRA 136, 142 (Aug. 1989).

41. Eric K. Noji et al., *Issues of Rescue and Medical Care Following the 1988 Armenian Earthquake*, 22 INT'L J. EPIDEMIOLOGY 1070, 1070 (1993).

42. See PETER WALKER, LEAGUE OF RED CROSS & RED CRESCENT SOCIETIES, INTERNATIONAL SEARCH AND RESCUE TEAMS: A LEAGUE DISCUSSION PAPER 26-29 (1991), <http://cidbimena.desastres.hn/docum/crid/Abril-Mayo2005/CD2/pdf/eng/doc1375/doc1375-contenido.pdf> [<http://perma.cc/6YCL-52JM>] (archived Sept. 22, 2015).

43. Office of the U.N. Disaster Relief Coordinator (UNDRO), *Third Meeting of Officials in Charge of National Emergency Relief Services (NERS III): Final Report*, at 11, UNDRO/89/20 (Oct. 19-20, 1989), <http://cidbimena.desastres.hn/pdf/eng/doc1794/doc1794-contenido.pdf> [<http://perma.cc/69NL-256W>] (archived Sept. 22, 2015).

44. U.N. OFFICE FOR THE COORDINATION OF HUMANITARIAN AFFAIRS [OCHA], INTERNATIONAL SEARCH AND RESCUE RESPONSE: MEETING OF INTERNATIONAL SEARCH AND RESCUE TEAM LEADERS ON LESSONS LEARNT AND FOLLOW UP TO THE 1999 TURKEY AND TAIWAN EARTHQUAKES 4 (1999).

45. See INT'L SEARCH & RESCUE ADVISORY GRP., INSARAG GUIDELINES VOLUME 1: POLICY 5 (2015), http://www.insarag.org/images/stories/INSARAG_Guidelines_V1_Policy1.pdf [<http://perma.cc/9PTN-7QCY>] (archived Sept. 10, 2015).

undertaken in 2015.⁴⁶ The group also drew global attention to its efforts by pursuing the December 2002 passage of UNGA Resolution 57/150: “Strengthening the Effectiveness and Coordination of International Urban Search and Rescue Assistance.” The resolution accomplished multiple objectives simultaneously, including officially recognizing INSARAG and promoting wider state participation in its efforts, urging disaster affected states to simplify border control procedures, recognizing the responsibility of USAR contributing states in deploying suitable teams and officially endorsing the INSARAG Guidelines.

However, it was INSARAG’s launch of its International External Classification process in 2005 that truly broke new ground in the world of international disaster relief and serves as a highly influential template for later efforts by the humanitarian health sector.⁴⁷ The premise behind the IEC is based on a search and rescue maxim that has continued through to the present day: the greatest proportion of live rescues will happen in the first twenty-four hours by the local inhabitants.⁴⁸ Those extricated during this period are typically closer to the surface and do not require sophisticated skill sets and equipment.⁴⁹ Therefore, what the impacted country really needs by the time external USAR personnel arrive are the advanced teams trained in highly technical rescues and possessing specialized equipment.

Prior to 2005, teams “self-classified” themselves when submitting their materials to be included in the international USAR directory relied upon by OCHA.⁵⁰ The subsequent decision to implement the peer-review classification process was an attempt to sift out search and rescue teams who would simply replicate local capacity or had no actual capacity at all.⁵¹ The IEC Guidelines identify three classifications: “light,” “medium,” and “heavy.” The categories vary depending on a number of elements, including the location of victims requiring USAR, building material involved, level

46. *Id.* at 4.

47. See Bookmiller, *supra* note 34, at 127.

48. See, e.g., Michael E. Durkin, et al., *The Survival of People in Collapsed Buildings*, DISASTER CHRONICLES, 1985, at 32–39; Osamu Kunii et al., *The Medical and Public Health Response to the Great Hanshin-Awaji Earthquake in Japan: A Case Study in Disaster Planning*, 2 MED. & GLOBAL SURVIVAL 214, 223–24 (1995); Anthony Macintyre et al., *Surviving Collapsed Structure Entrapment After Earthquakes: A “Time-to-Rescue” Analysis*, 21 PREHOSPITAL & DISASTER MED. 4, 8 (2006).

49. See Macintyre et al., *supra* note 48, at 8.

50. INT’L SEARCH & RESCUE ADVISORY GRP., INSARAG EXTERNAL CLASSIFICATION/RECLASSIFICATION (IEC/R) HANDBOOK 7 (2012) [hereinafter INSARAG HANDBOOK], <https://docs.unocha.org/sites/dms/Documents/IEC-R%20Handbook%202012%20Edition.pdf> [<http://perma.cc/BZ2F-TPMZ>] (archived Sept. 10, 2015).

51. See Arjun Katoch, *The Responders’ Cauldron: The Uniqueness of International Disaster Response*, 59 COLUM. J. INT’L AFF. 153, 167–68 (2006).

of medical expertise required, ability to mobilize quickly, required length of continuing operations, self-sufficiency, scope and sophistication of equipment, and depth of personnel expertise. The “light” designation applies to first responders who have the ability to assist victims lightly trapped or close to the surface and who are typically reached in the hours right after the event takes place.⁵² These rescuers, on average, are either from the country impacted or from neighboring states.⁵³ USAR teams who meet the requirements of the “medium” or “heavy” classification must demonstrate best practices in five areas: management, logistics, search, rescue, and medical.⁵⁴ Personnel in these categories are trained to respond to highly complex and technical rescues.⁵⁵ The highest classification of “heavy” means that the team already contains expertise in locating the “deeply entombed” in structures with reinforced steel, possesses the ability to search at two sites simultaneously, has built-in capacity to locate victims with both search dogs and technology, has proficiency in both heavy rigging and lifting, and able to be self-sufficient for and conduct continuous twenty-four hour operations for up to ten days at two different sites. In addition, they must have the capability to be on-site and operational within forty-eight hours.⁵⁶

National teams who achieve the medium or heavy classification understand that they must respect the authority of the Local Emergency Management Authority and participate through the UN OCHA coordination mechanisms, including the On-Site Operations Coordination Center (OSOCC) mechanism and the United Nations Disaster Assessment and Coordination (UNDAC) process.⁵⁷ OSOCC, the first initiative pursued by INSARAG in the 1990s, provides a central rendezvous point for incoming international USAR teams.⁵⁸ The OSOCC’s Reception and Departure Centers (RDCs), typically located at designated entry points in the disaster-stricken country, are responsible for proactively addressing issues that may impede the successful deployment of USAR personnel, including customs and immigration, transportation logistics, and interpretation support.⁵⁹

52. INT’L SEARCH & RESCUE ADVISORY GRP., INSARAG GUIDELINES VOLUME II: PREPAREDNESS AND RESPONSE, CHAPEAU, MANUAL A: CAPACITY BUILDING 34 (2015) [hereinafter INSARAG GUIDELINES VOL. II], http://www.insarag.org/images/stories/INSARAG_Guidelines_V2_Chapeau_Manual_A_-_Capacity_Building1.pdf [<http://perm.a.cc/4STL-8KRN>] (archived Sept. 10, 2015).

53. *See id.* at 33.

54. *See* INSARAG HANDBOOK, *supra* note 50, at 7–9.

55. *See id.*

56. INSARAG GUIDELINES VOL. II, *supra* note 52, at 35–36.

57. *See* U.N. OFFICE FOR THE COORDINATION OF HUMANITARIAN AFFAIRS, ON-SITE OPERATIONS COORDINATION CENTRE (OSOCC) GUIDELINES 11 (2014) [hereinafter ON-SITE OPERATIONS GUIDELINES].

58. *See id.* at 9–11.

59. *Id.* at 14, 33–41.

The RDC is also tasked with registering incoming teams and conveying their status to the OSOCC.⁶⁰ As personnel exit the country, the RDC conducts a debriefing, logs their departure and works to resolve any outstanding matters.⁶¹ Both the RDC and the OSOCC are set up either by the first USAR team to arrive in country, or by representatives from the UNDAC team.⁶² UNDAC is a corresponding rapid response mechanism, involving a global roster of national and IGO-affiliated emergency management officials who mobilize quickly and assist the affected country in articulating its needs and coordinating the influx of global relief when appropriate.⁶³ For countries willing to accept UN-facilitated external aid in the wake of a disaster, the establishment of an OSOCC is now standard operating procedure across the humanitarian system during a large-scale international relief operation, and the efforts have paid off according to several studies.⁶⁴ As long-time UN humanitarian affairs official Arjun Katoch explains, “[i]t simultaneously established a process for mutual assessment of international USAR team operational capabilities and made it clear that light USAR teams should not respond internationally as they lack adequate operational capability.”⁶⁵

IV. REPLICATING THE “INSARAG MODEL” IN THE HUMANITARIAN HEALTH SECTOR: WHO AND FOREIGN MEDICAL TEAMS

Like USAR personnel, emergency medical professionals may also be domestic-based emergency service providers who may deploy on an episodic basis to international disasters. As with international USAR, especially in its formative stages, the sector frequently attracts volunteers that either possess expertise ill-suited for the impacted country’s demonstrated needs or little training at all. In 2011, the World Health Organization (WHO) (in conjunction with the Global Health Cluster) established a new working group focusing on classification, standard setting, and registration procedures for Foreign Medical Teams.⁶⁶ WHO was galvanized to act after numerous

60. *Id.* at 14.

61. *Id.* at 39–41.

62. *Id.* at 14.

63. *What is UNDAC?*, OCHA, <http://www.unocha.org/what-we-do/coordination-tools/undac/overview> [<http://perma.cc/Q88Q-2AMU>] (archived Sept. 27, 2015).

64. *See, e.g.*, U.N. OFFICE FOR THE COORDINATION OF HUMANITARIAN AFFAIRS [OCHA], HUMANITARIAN RESPONSE REVIEW 36 (2005) [hereinafter HUMANITARIAN RESPONSE REVIEW], https://interagencystandingcommittee.org/system/files/legacy_files/HRR.pdf [<https://perma.cc/U9HS-QWNA>] (archived Sept. 22, 2015).

65. Katoch, *supra* note 51, at 167.

66. INTER-AGENCY STANDING COMM., WORLD HEALTH ORG., GLOBAL HEALTH CLUSTER MEETING REPORT 15–16 (2011), http://www.who.int/hac/global_health_cluster/

problems were observed during the responses to the 2010 Haitian earthquake and Pakistan floods in terms of training levels, professionalism, and coordination among arriving medical personnel from abroad.⁶⁷

After the wave of complex humanitarian emergencies in 1990s, the health community was coming to terms with a dynamic that did not exist for the urban search and rescue sector. While USAR was deployed primarily to sudden onset disasters caused by earthquakes, foreign medical personnel served both crises with a significant violence element as well those that were hazards based, and one size did not fit all on the humanitarian health front. As Rony Brauman writes: "The most widespread misinterpretation is that natural disasters produce the same type of consequences as armed conflicts. They do not."⁶⁸ Brauman identifies several key differences that completely shape the nature of the outside medical response required. Natural disasters are more likely to impact a specific geographic region, leaving the majority of the emergency medical provision intact and therefore necessitating an in-country stay shorter in duration.⁶⁹ Wars, on the other hand, affect a much larger area, damage hospitals and prompt the flight of local medical professionals.⁷⁰ The displaced populations may also be malnourished and, therefore, more vulnerable to epidemics, which is not necessarily a primary characteristic of natural disaster contexts.⁷¹

As early as 1999, in the wake of Hurricanes Georges (1998) and Mitch (1999), the Pan American Health Organization's (PAHO) report on the respective international responses affirm these important distinctions and their implications for external medical provision.⁷² In its section on emergency medical care related to the two quakes, the findings and recommendations parallel INSARAG's earlier experiences and also presage the very concerns that WHO's FMT initiative would wrestle with over ten years later. The report noted: (1) due to the lag time in international responders reaching impacted communities, local, regional, and national providers were the primary

about/global_health_cluster_report_23march2011.pdf?ua=1 [http://perma.cc/BZH8-AG3Y] (archived Sept. 10, 2015).

67. FOREIGN MED. TEAM WORKING GRP., WORLD HEALTH ORG., *Humanitarian Health Action: Improving the Quality of Surgical Trauma Care After Sudden Onset Disasters*, http://www.who.int/hac/global_health_cluster/fmt/en/ [http://perma.cc/3G5T-C5DC] (archived Sept. 10, 2015).

68. Rony Brauman, *Global Media and the Myths of Humanitarian Relief: The Case of the 2004 Tsunami*, in HUMANITARIANISM AND SUFFERING: THE MOBILIZATION OF EMPATHY 108, 110 (Richard Ashby Wilson & Richard D. Brown eds., 2d ed. 2011).

69. *Id.*

70. *Id.*

71. *Id.*

72. See PAN AM. HEALTH ORG. & WORLD HEALTH ORG., CONCLUSIONS AND RECOMMENDATIONS: MEETING ON EVALUATION OF PREPAREDNESS AND RESPONSE TO HURRICANES GEORGES AND MITCH 11-12 (1999).

emergency medical care providers; (2) the arrival of a wave of “foreign medical brigades” after the initial aftermath—many whose services were no longer required—placed a significant burden upon, and therefore diverted the attention of the local authorities from articulating its most pressing post-disaster needs; (3) foreign medical teams could be useful in the “medium term” in specialty areas once needs were assessed by the local authorities but should only come at the request of the impacted country; and (4) those teams that would participate in the response must be self-sufficient in terms of logistical and technical support as well as take appropriate precautions regarding the introduction of diseases not endemic in the host country.⁷³

Again echoing many of the themes faced by international USAR, Claude de Ville de Goyet, assessing the international medical response to the 1999 Marmara earthquake, challenged the conventional wisdom of the time both in light of what transpired in Turkey and the earthquakes in the Americas:

[O]nly a handful of survivors owe their lives to foreign teams. Most survivors owe their lives to neighbours and local authorities. When foreign medical teams arrive, most of the physically accessible injured have already received some medical attention. Western medical teams are not necessarily most appropriate to the local conditions. Many will have found that press coverage of the Turkey earthquake created a sense of déjà vu: international rescue teams rushing in were made to look as though they were saving victims neglected by incompetent or corrupt local authorities.⁷⁴

The 2005 *Humanitarian Response Review*, commissioned by UNOCHA in the months before the December Pakistan earthquake of the same year, warned that a massive influx of emergency medical personnel post-disaster, many with highly variable levels of training, was shaking the confidence of impacted governments: “In recent years, organizations are reporting more and more scepticism among authorities, when bringing in expatriate health personnel, especially in relation to professional quality and skills, and compatibility with national regulations.”⁷⁵

International volunteer medical responses during the arc of natural disasters beginning with the 2004 Indian Ocean tsunami through the 2010 Haitian earthquake further solidified the substantial criticisms of such assistance both pertaining to their quality and necessity. Dissatisfaction amongst governments and

73. See *id.* at 21–22.

74. Claude de Ville de Goyet, *Stop Propagating Disaster Myths*, 16 HUMANITARIAN EXCHANGE MAG. 8 (March 2000), <http://www.odihpn.org/humanitarian-exchange-magazine/issue-16/stop-propagating-disaster-myths> [http://perma.cc/G44Y-TEAJ] (archived Sept. 10, 2015).

75. HUMANITARIAN RESPONSE REVIEW, *supra* note 64, at 32.

within the international humanitarian health community itself focused on several interrelated problem areas. First, the numbers of outside professional medical teams and volunteers often far exceeded the assessed need of the impacted country and many arrived too late following the “golden period.”⁷⁶ Following the 2004 Indian Ocean Tsunami, Thailand, due to a variety of favorable circumstances—including that many of its high quality medical facilities were left largely unaffected by the disaster—required no outside medical assistance nor did Bangkok request any. However, a wealthy donor state still sent a medical team of ten personnel, a typical reaction which the Thai government found “patronizing,” according to WHO’s in-country coordinator.⁷⁷

Second, thousands of volunteers, unaffiliated with the major international emergency medical providers, arrived with inappropriate credentials and supplies related to the specific needs landscape and little or no training in international disaster response, including being unfamiliar with the international humanitarian assistance infrastructure such as the role of UNOCHA or the Cluster System.⁷⁸ Moreover, some arrived with no actual professional credentials at all.⁷⁹ In all cases, the influx of such individuals further stressed already overburdened domestic and international system response capacities.⁸⁰ An experienced member of the Mount Sinai Hospital medical team, which had joined the Haiti-based organization Partners in Health to participate in the Haitian response, explained what he observed:

With healthcare facilities in tatters, the needs were the greatest for trauma-trained personnel, emergency medical staff, and other practitioners who could perform under the most difficult circumstances. A surgeon who exclusively practices minimally invasive or robotic surgery would be of little use in these circumstances Similarly, there is very little that can be accomplished in a disaster theater by a lone healthcare volunteer who does not embed himself or herself into an appropriate relief organization. In addition to the challenges of

76. See Natacha Emerson et al., *First 30 days: Organizing Rapid Responses*, 20 PREHOSPITAL & DISASTER MED. 420, 420–421 (2005).

77. Jonathan Watts, *Thailand Shows The World It Can Cope Alone*, 365 LANCET 284, 284 (2005).

78. Ezra Fieser & Sara Miller Llana, *Haiti Earthquake Anniversary: The State of Global Disaster Relief*, CHRISTIAN SCI. MONITOR (Jan. 11, 2011), <http://www.csmonitor.com/World/Global-Issues/2011/0111/Haiti-earthquake-anniversary-the-state-of-global-disaster-relief> [<http://perma.cc/43XV-8TZ6>] (archived Sept. 10, 2015).

79. See Van Hoving et al., *supra* note 23, at 202.

80. See CLAUDE DE VILLE DE GOYET ET AL., PAN AM. HEALTH ORG. (PAHO), HEALTH RESPONSE TO THE EARTHQUAKE IN HAITI: LESSONS TO BE LEARNED FOR THE NEXT MASSIVE SUDDEN-ONSET DISASTER 111–36 (Jan. 2010); Ernest Benjamin et al., *Principles and Practice of Disaster Relief: Lessons from Haiti*, 78 MOUNT SINAI J. MED. 306, 314 (2011); Van Hoving et al., *supra* note 23, at 201–02; Fieser & Llana, *supra* note 78.

finding something useful to do, there are the difficult problems of credentials vetting and logistics such as local transportation, lodging, and safety.⁸¹

Furthermore, foreign medical personnel frequently failed to respect local medical personnel, culture, and protocols. One study related to malaria control in Sri Lanka after the 2004 Tsunami showed that while local authorities had an operational plan, the presence of 600 foreign doctors independently operating their own camps and implementing their own protocols and medical treatments negatively impacted the domestic monitoring system in place.⁸² During the response on the Indonesian island of Aceh, local medical personnel were essentially frozen out of their own hospital facilities by outside medical relief workers according to an Indonesian medical doctor:

International medical responders, for example, brought their own equipment and set up small mobile hospitals, but later found they required facilities in existing hospitals. Consequently, many demanded exclusive use and control of hospital wards. An operation theater in Meulaboh, for example, was "controlled" by international medical teams who shared the facility with each other on a rotational basis. As a result, some Indonesian doctors lost access to both their facilities and patients.⁸³

In Haiti, volunteers performed medical procedures used elsewhere for limb amputation that were ill-suited for the open air conditions in which many of the treated would be recovering.⁸⁴ Even internationally sensitive medical professionals may struggle with the substantive differences in medical approaches in differing national contexts, attempting to reconcile divergent systems for patient care and support, and pursuing what they may believe is the best approach to medical treatment in what may be in contrary to local practices.⁸⁵

While less egregious from a life-saving perspective, medical providers without sensitivity to the broader cultural landscape has also been an issue. On the island of Aceh in 2004, many medical personnel serving a population traumatized by decades of violence

81. Benjamin, *supra* note 80, at 314.

82. Olivier Briët et al., *Maps of the Sri Lanka Malaria Situation Preceding the Tsunami and Key Aspects to be Considered in the Emergency Phase and Beyond*, 4 *MALARIA J.* 8 (2005), <http://www.malariajournal.com/content/4/1/8> [<http://perma.cc/F42U-9KJ3>] (archived Sept. 10, 2015).

83. Eddy Rahardjo et al., *Toward More Efficient Multinational Work on Rescue and Aid for Disasters: Lessons Learned During the Aceh Tsunami and Yogya Earthquake*, 23 *PREHOSPITAL & DISASTER MED.* 301, 302 (2008).

84. Costello, *supra* note 1.

85. Matthew Hunt, *Ethics Beyond Borders: How Health Professionals Experience Ethics in Humanitarian Assistance and Development Work*, 8 *DEVELOPING WORLD BIOETHICS* 59, 63–65 (2008).

were in “battle suits” rather than professional wear more associated with the medical profession.⁸⁶ While international responders were generally lauded for their sensitivity in the highly conservative Muslim areas during the 2005 Pakistan Earthquake, there was still an issue of the 2,500 Cuban medical providers who “had no idea where they were and asked us where to find rum. They were unprepared in terms of clothing, had no warm clothes, often walked around in inappropriate clothes, and would go to the river to wash in public.”⁸⁷

Finally, the international emergency medical community, even among the established international providers, failed to provide a coordinated and cohesive response even when such teams were sought after by a disaster stricken country. A WHO Special Report regarding medical provision following the 2004 Tsunami concluded that beyond the issue of lost hours due to a lack of coordination within the sector, the same impacted populations experienced numerous repeated medical assessments by a wide variety of organizations.⁸⁸ In Indonesia, reports documented little information exchange or coordination among international teams.⁸⁹ During the 2005 Pakistan Earthquake, the lack of coordination between the Pakistani military and outside medical providers resulted in some areas being flooded by field hospitals, while others had none.⁹⁰ A Doctors Without Borders team in Haiti also cited issues of uneven coverage, thousands of patients left without post-operative care, rudimentary referral systems, a lack of a common field reference system, and weak recordkeeping.⁹¹

V. A FIRST STEP TOWARD PROFESSIONAL ORDER? WHO'S FOREIGN MEDICAL TEAM CLASSIFICATION PROCESS

The first substantive policy effort regarding international medical relief standards pertained specifically to Foreign Field

86. Rahardjo, *supra* note 83, at 302.

87. ANDREW WILDER, FEINSTEIN INT'L CTR., PERCEPTIONS OF THE PAKISTAN EARTHQUAKE RESPONSE 29 (2008).

88. Mukesh Kapila et al., *Health Aspects of the Tsunami Disaster in Asia*, 20 PREHOSPITAL & DISASTER MED. 368, 370 (2005).

89. Rahardjo, *supra* note 83, at 302.

90. Esther Hicks & Gregory Pappas, *Coordinating Disaster Relief After the South Asia Earthquake*, SOC'Y, July–Aug. 2006, at 45.

91. Kathryn Chu et al., *Improving Effective Surgical Delivery in Humanitarian Disasters: Lessons from Haiti*, 8 PUB. LIBRARY SCI. MED. 1, 1 (2011); see also Anthony Redmond, *A Qualitative and Quantitative Study of the Surgical and Rehabilitation Response to the Earthquake in Haiti, January 2010*, 26 PREHOSPITAL & DISASTER MED. 449–56 (2011).

Hospitals (FFHs), issued by WHO and PAHO in 2003.⁹² Following the highly complex and problem-riddled Haiti response, invested parties in humanitarian health met under the auspices of WHO and PAHO again for technical consultations in Havana, Cuba in December 2010.⁹³ During this meeting, Foreign Medical Teams became the official focus and point of reference, folding the previous issue of FFHs into the larger discussion of professional, principled, and needs-based medical provision during disasters.⁹⁴ The meeting established several key parameters for the subsequent policy dialogue on the subject: (1) That the effort would focus specifically upon medical relief following sudden onset disasters, and initially upon earthquake-related response only; (2) that the professionalization process would begin initially with a self-registration system but would ultimately expand to include an accreditation mechanism and establishment of minimum standards for FMTs; and (3) that the FMT framework should be designed to support—not replace—the impacted government and national health care systems.⁹⁵ The proceedings and official annexes make repeated reference to the usefulness of the INSARAG model in several of these areas.⁹⁶

The international policy momentum continued following the Havana meeting, with particular attention being paid to the organization of an FMT registry to address issues related to pre-deployment and on-site coordination amongst the teams themselves and the host government. The proposal was further refined during follow-up meetings by the WHO's Global Health Cluster (GHC) in spring 2011, assuming a more specific focus on trauma care and surgical teams and launching the formal creation of a "Foreign Medical Teams Working Group" (FMT-WG) under the auspices of the GHC.⁹⁷

Since its inception, the Working Group has made rather impressive strides in getting the FMT initiative launched, with

92. PAN AM. HEALTH ORG. [PAHO], WHO-PAHO GUIDELINES FOR THE USE OF FOREIGN FIELD HOSPITALS IN THE AFTERMATH OF SUDDEN-IMPACT DISASTERS 5-6 (July 8-10, 2013) [hereinafter FOREIGN FIELD HOSPITAL GUIDELINES], http://www.paho.org/disasters/index.php?option=com_content&view=article&id=674&lang=en [<http://perma.cc/CV88-EVKN>] (archived Sept. 22, 2015).

93. PAN AM. HEALTH ORG. [PAHO], PROCEEDINGS OF THE WHO/PAHO TECHNICAL CONSULTATION ON FOREIGN MEDICAL TEAMS (FMTs) POST SUDDEN ONSET DISASTERS (SODs) 2 (Dec. 7-9, 2010), http://www.paho.org/disasters/index.php?option=com_docman&task=doc_view&gid=1761&Itemid= [<http://perma.cc/6EGC-RAV9>] (archived Sept. 22, 2015).

94. *Id.* at 3.

95. *Id.*

96. *See id.* at 6-7, 12, 17-18.

97. WORLD HEALTH ORG. [WHO], REGISTRATION AND COORDINATION OF FOREIGN MEDICAL TEAMS RESPONDING TO SUDDEN ONSET DISASTERS: THE WAY FORWARD 2 (May 5, 2013), http://www.who.int/hac/global_health_cluster/fmt_way_forward_5may13.pdf [<http://perma.cc/ERE9-EMW6>] (archived Sept. 22, 2015).

significant input from a wide variety of humanitarian health stakeholders. The Group acknowledges that several forces help advance the framework, including: (1) INSARAG's active encouragement throughout the process, both in its sharing of expertise and experiences related to registration and classification as well as its ability to absorb FMTs into the already existing OSCOCC and RDC mechanisms; (2) WHO's own corresponding efforts to further strengthen its surge response strategy via its 2013 Emergency Response Framework document; and (3) the renewed commitment by key players to further advance the cause of overall coordination and professionalism in humanitarian relief through the IASC's Transformative Agenda process launched in December 2011.⁹⁸

In September 2013, the FMT Working Group issued the inaugural set of FMT-related guidelines titled "Classification and Minimum Standards For Foreign Medical Teams in Sudden Onset Disasters."⁹⁹ This 103 page foundational document achieves what at first appear to be modest goals. Yet, in reality, it is the first substantive global effort to organize and professionalize the medical sector outside the highly narrow subset of field hospitals and across all types of teams, whether governmental or nongovernmental. From the outset, it introduces a more meaningful definition for the term "Foreign Medical Team." Rather than simply connoting a source of medical provision originating outside the disaster impacted country's borders, it becomes an official classification, "exclusively used for those international medical teams that have registered and [agree] to comply with the standards and principles," including having "staff to provide basic and/or advanced healthcare based on international classification levels and minimum standards during a limited time period . . ."¹⁰⁰ Highly notably, the definition also directly addresses the issue of unaffiliated volunteers: "Any individuals or groups that do not fit within the definition and cannot comply with the standard should either consider joining a recognized organization that provides FMT or not responding in the aftermath of the sudden onset disaster."¹⁰¹

This first edition of the classification/standards further establishes that being recognized as a Foreign Medical Team means that the unit assumes the responsibility of adhering to six "Guiding Principles," including that care will be needs based and medically

98. *Id.*

99. *See generally* WORLD HEALTH ORG. [WHO], CLASSIFICATION AND MINIMUM STANDARDS FOR FOREIGN MEDICAL TEAMS IN SUDDEN ONSET DISASTERS (2013), [hereinafter CLASSIFICATION AND MINIMUM STANDARDS], http://www.who.int/hac/global_health_cluster/fmt_guidelines_september2013.pdf [<http://perma.cc/Y9JB-9MUZ>] (archived Sept. 22, 2015).

100. *Id.* at 27.

101. *Id.*

ethical, accountable, and collaborative.¹⁰² “Core FMT Standards” specifically framed around the conduct of the response itself are also delineated, ranging from the agreement to register with relevant national and international authorities to ensuring self-sufficiency for the entire duration of stay in country to making a commitment to carry appropriate malpractice insurance.¹⁰³

An opening effort at an FMT self-classification process is also included. Segmented into three types, the classifications differ depending on a variety of factors: whether the care is on an outpatient or inpatient basis, level of complexity of care, number of patients that can be cared for per day, hours of operation (day only or twenty-four hour), whether or not they bring their own medical structures, speed in deployment, and length of stay.¹⁰⁴ On the one end of the spectrum, FMT Type 1 is outpatient based, emergency medical care for at least one hundred patients.¹⁰⁵ The teams are expected to deploy fastest to the site--between twenty-four and forty-eight hours—and are to be “light and portable.”¹⁰⁶ They may or may not rely on local facilities and are not expected to function on a twenty-four hour basis.¹⁰⁷ They are expected to stay within the country ideally no more than a few weeks.¹⁰⁸ On the other end is FMT Type 3, delivering “complex inpatient referral surgical care,” possessing the competency to address thirty minor or fifteen major surgical cases per day and have the means for 24/7 support and monitoring, among other capabilities.¹⁰⁹ These teams may establish their own field hospital or integrate within local structures, but due to their complexity, are not expected to be operational until five to seven days following the disaster and will remain for a minimum of two months.¹¹⁰ This latter requirement addresses previous concerns especially raised in Haiti that many external individual surgeons or teams provided the initial surgery but then departed so abruptly that patients suffered with the lack of any specialized follow-up care.¹¹¹ There is also one additional category titled “Additional Specialised Care Teams,” focusing on additional experts such as burn care or dialysis.¹¹² In this case, the teams must integrate within local or Type

102. *Id.* at 18.

103. *Id.* at 19.

104. *Id.* at 34–43.

105. *Id.* at 34–35.

106. *Id.* at 35.

107. *Id.* at 34.

108. *See id.* at 35.

109. *Id.* at 36–37.

110. *Id.* at 37.

111. *See* FOREIGN FIELD HOSPITAL GUIDELINES, *supra* note 92, at 31.

112. CLASSIFICATION AND MINIMUM STANDARDS, *supra* note 99, at 37–38.

2 or 3 facilities with advanced approval of the host governing authority.¹¹³

This classification process is entirely based on self-assessment by the medical providers themselves, rather than linked to an external peer review, an opening strategy that INSARAG also adopted.¹¹⁴ The process to date works in a particular way. First, FMTs complete a self-registration form with the WHO that confirms their capacity related to the various classifications and their agreement to comply with the expressed Guiding Principles and Standards. Registration, however, does not in any way signify that the team may now automatically proceed to a sudden onset disaster affected state. Next, in order to participate in the relief response, the governing authority of the impacted country must then provide authorization to provide services “at their discretion.”¹¹⁵

As is unfortunately often the case in the international humanitarian assistance field, the new WHO FMT self-classification process was put to the test within just a few short months of being promulgated. In November 2013, devastating Typhoon Haiyan struck the Philippines, widely considered to be the most powerful recorded cyclone ever to strike land and taking over 6,000 lives.¹¹⁶ The Philippine government actively promoted the FMT registration form process on its embassy and consular websites worldwide and media outlets serving the Philippine expatriate community also circulated information related to the registration form and the need to obtain authorization from Manila.¹¹⁷ Signs were also posted on site indicating that arriving teams should register.¹¹⁸

During a three month period following the disaster, 151 outside medical contingents were documented as participating in the response, with WHO’s Country office registering the teams.¹¹⁹ The

113. *Id.* at 38.

114. INSARAG HANDBOOK, *supra* note 50, at 7.

115. *See id.* at 12–13, 29.

116. *See generally* Typhoon Haiyan—Nov. 2013, RELIEFWEB, <http://reliefweb.int/disaster/tc-2013-000139-phl> [<http://perma.cc/M5FL-MM2P>] (archived Sept. 22, 2015).

117. *See, e.g.*, Advisory No. 7: *Guidelines on the Acceptance of Foreign Medical Teams*, PHILIPPINE CONSULATE GENERAL IN SAN FRANCISCO (Nov. 25, 2013), <http://www.philippinessanfrancisco.org/news/3733/301/ADVISORY-NO-7-GUIDELINES-ON-THE-ACCEPTANCE-OF-FOREIGN-MEDICAL-TEAMS/d,phildet/> [<http://perma.cc/G6DN-AGK4>] (archived Sept. 22, 2015); *see also* *Guidelines Released for Foreign Medical Teams Traveling to ‘Yolanda’ Areas*, INQUIRER.NET (Nov. 27, 2013, 8:20 AM), <http://globalnation.inquirer.net/92461/guidelines-released-for-foreign-medical-teams-traveling-to-yolanda-areas#ixzz3ajq1jtMY> [<http://perma.cc/YH4J-69MR>] (archived Sept. 22, 2015).

118. Hilarie Cranmer, *Typhoon Haiyan and the Professionalization of Disaster Response*, 370 NEW ENG. J. MED. 1185, 1185 (2014).

119. *Philippines Health Cluster Bulletin*, WORLD HEALTH ORG. [WHO], May 16, 2014, at 11, http://www.wpro.who.int/philippines/typhoon_haiyan/media/Haiyan.

majority were Type 1 Primary Care teams, thirteen falling under Type 2 classification and with only two in the more complex Type 3 category.¹²⁰ Both Philippine government officials and outside observers who participated in the relief operation were encouraged by the initial results of the process.¹²¹

Yet the Haiyan case also demonstrates that profound and significant issues remain related to international medical provision in the wake of sudden onset disasters. Setting aside that just over half of the FMTs did not register with WHO, this statistic solely represents the teams that the government and WHO actually were aware of, and within even that subset there remained a significant paucity of information regarding the exact nature of their activities in country.¹²² Internet blog postings by international medical responders to Haiyan effectively capture the challenges that remain for the WHO-FMT initiative. One team was literally on its way to perform elective surgeries in Mexico when it changed course and proceeded to the Philippines. One of its members wrote about their complete lack of preparation for the trip:

Logistical obstacles were formidable: We had no flight, no visas, no official permissions, no contacts on the ground or with any other NGOs aside from Rubicon [who invited them spur of the moment to join their organization], no security, none of the required or suggested vaccinations, no idea how we'd get from Manila to the disaster area (if we could even get to Manila), nor what sort of facilities we'd find, if any, once we got to wherever it was we needed to go. What if half the group didn't want to go? What if we ended up stuck in an airport terminal for a week? What if things turned violent?¹²³

Concerns also remain regarding the still significant delay in team arrivals and what services will be useful by the time groups do make it to a site. It was three weeks after Haiyan had struck before the greatest number of FMTs were up and running.¹²⁴ Other post-

HealthClusterBulletin19.16May2014.pdf?ua=11 [http://perma.cc/DJU3-ZM2C] (archived Sept. 22, 2015).

120. *Id.*

121. See Cranmer, *supra* note 118, at 1186–87; Press Release, Republic of Philippines, Department of Health, Sec. Ona Addresses Foreign Medical Teams After Action Review (August 12, 2014), <http://www.healthpromo.doh.gov.ph/foreign-medical-teams-after-action-review-fmt-aar/> [http://perma.cc/JH8J-ZF9F] (archived Sept. 27, 2015).

122. Kim Brolin, *Foreign Medical Teams in the Philippines After Typhoon Haiyan 2013—Who Were They, When Did They Arrive and What Did They Do?*, PLOS CURRENT DISASTERS (May 5, 2015), at 10–11, <http://currents.plos.org/disasters/article/dis-15-0018-foreign-medical-teams-in-the-philippines-after-typhoon-haiyan-2013-who-were-they-when-did-they-arrive-and-what-did-they-do/> [http://perma.cc/9T5W-37RG] (archived Sept. 22, 2015).

123. David Page, *In the Wake of a Typhoon, a Surprising Discovery: Part One*, TAKEPART.COM (Jan. 12, 2014), <http://www.takepart.com/feature/2014/01/09/philippines-typhoon-haiyan-medical-relief-diary-part-1>.

124. Cf. Brolin, *supra* note 121, at 6–7.

disaster evaluations lamented the persistent pattern that the international response continued to overwhelm, rather than appropriately partner, with local health stakeholders¹²⁵ and that the suitable balance had not been struck between the full range of needs of the impacted population (i.e., neo-natal services) as opposed to the heavy emphasis on trauma surgery providers.¹²⁶

VI. CONCLUSION

In endeavoring to both internally cultivate a set of professional standards for its community as well as externally earn the good faith of disaster affected states, the WHO's recent Foreign Medical Team Classification and Registration schemes not only complement IDRL, as the authors of the defining document state,¹²⁷ but show promise in becoming part of the International Disaster Response Law soft law canon. While there are many substantive differences between the USAR and emergency medical fields, including the wider variety of actors involved on the medical side, domestic credentialing requirements and the longer duration of in-country service, the FMT journey to state recognition equal to INSARAG's shows early potential. Future research following subsequent disasters such as the various assessments post-Haiyan will be warranted to determine the degree of national governments' and the medical sector's embrace of the concept.

Currently, international disaster law's overarching normative framework is to have national and local government authorities reduce risk and fortify their domestic capabilities so that an international disaster response will be decreasingly warranted over time. However, in light of countries with extraordinary vulnerability and economic constraints, such as Haiti, Pakistan, or Nepal, and on the other end of the spectrum, the difficulties faced even by economically prosperous countries such as the United States, Japan, and New Zealand following their own natural disaster experiences, a future without international disaster response is unfortunately very far way. In the meantime, cross-border humanitarian relief will only

125. Andy Featherstone, *Missed Again: Making Space for Partnership in the Typhoon Haiyan Response* (June 2014), at 24–26, http://www.academia.edu/8983550/Featherstone_A_2014_Missed_Again_making_space_for_partnership_in_the_Typhoon_Haiyan_response [<http://perma.cc/XC5F-WULJ>] (archived Sept. 22, 2015).

126. Julie Hall, *Typhoon Haiyan: Lessons from the Response and How to Prepare for the Future*, HUMANITARIAN EXCH. (Jan. 2015), <http://www.odihpn.org/humanitarian-exchange-magazine/issue-63/typhoon-haiyan-lessons-from-the-response-and-how-to-prepare-for-the-future> [<http://perma.cc/6A28-LRDC>] (archived Sept. 22, 2015).

127. See CLASSIFICATION AND MINIMUM STANDARDS, *supra* note 99, at 21.

be improved if governments of disaster-impacted countries, the United Nations and the major relief sectors themselves strongly work in tandem to enforce relevant standards and guidelines in the wake of a sudden onset disaster.