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First Aid in Humanitarian Settings: Life-Saving Actions and Field Emergencies

Complete manual

A 3-day certified course: securing the scene, assessing a casualty, calling for help, performing cardiopulmonary resuscitation, stopping severe bleeding, and managing choking, burns, fractures, heat, dehydration and bites, as well as providing psychological first aid, with a final assessment and a verifiable certificate. Based on IFRC guidelines, it does not replace hands-on training on a manikin with a National Red Cross or Red Crescent Society.

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Day 1 : Safety, assessment and alert

Objectives

- Understand the role and limits of a first aider.
- Secure the scene and protect yourself from infection.
- Assess a casualty and give a complete alert.

The first aider's role: protect, alert, assist

First aid is the help given by a person on the spot, with little or no equipment, until medical help arrives. It has three aims: **preserve life**, **prevent deterioration** and **promote recovery**.

The approach fits in three words: **protect** (yourself, the casualty and bystanders), **alert** (emergency services or the nearest health facility, according to your organisation's medical plan) and **assist** (the right actions, within the limits of your training).

In humanitarian settings, medical help may be hours away. A first aider must therefore be able to **monitor** a casualty for a long time and know the organisation's **medical evacuation plan** (MEDEVAC): who to call, which vehicle, which health facility, how far away.

Securing the scene and protecting yourself

Before touching a casualty, look around: traffic, fire, electric wires, unstable buildings, a hostile crowd, the risk of a **second explosion** after a first one. An injured first aider is one more casualty. If the danger cannot be removed, and only if it is possible without risk, move the casualty; otherwise, wait for the right resources.

- Wear **gloves** whenever there is blood or body fluids; if none are available, use a clean plastic bag.
- Wash your hands before and after, or use alcohol-based hand rub.
- If the casualty's blood comes into contact with a wound or mucous membrane, or after a needle-stick: wash, then seek medical advice immediately for possible **post-exposure prophylaxis** (to be started as soon as possible, within 72 hours at the latest).

Assessment: response, airway, breathing

The assessment follows a fixed order, dealing first with what kills fastest.

1. **Response**: speak loudly, tap the shoulders. "Can you hear me? Open your eyes."
2. **Catastrophic bleeding**: visible heavy bleeding is treated immediately, before anything else.
3. **Airway**: in an unresponsive casualty, gently tilt the head back and lift the chin.
4. **Breathing**: look, listen and feel for **no more than 10 seconds**. Gasps (infrequent, noisy breaths) are **not** normal breathing.

If the casualty is not breathing normally: have someone call for help and fetch a defibrillator, and start resuscitation (day 2). If they are breathing: recovery position, then a full head-to-toe check (wounds, pain, deformities) and monitoring.

Calling for help: a clear and complete message

Who to call depends on the context: the national emergency number if it exists and works, otherwise the organisation's **medical or security focal point**, the referral health facility or the local Red Cross or Red Crescent. These numbers must be in every vehicle and in the security plan.

The message always follows the same order:

- **Where**: exact location, landmarks, GPS coordinates if possible.
- **What**: type of accident or illness, number of casualties.
- **Condition**: response, breathing, bleeding, actions already taken.
- **Who**: your name and a call-back number. Only hang up when the other person tells you to.

The professional framework: standards, duty of care and the first aider's limits

> This online course provides knowledge, method and clinical reasoning. It is in no way a substitute for certified hands-on first aid training, with scenario practice and manikin training, delivered by a Red Cross or Red Crescent National Society or by an accredited provider in your country. Skills are learned with the hands, under the eye of an instructor, and are maintained through regular refresher training.

First aid is not a scaled-down version of emergency medicine: it is a discipline in its own right, with its own evidence-based recommendations. The international reference for the Red Cross and Red Crescent Movement is the **International First Aid, Resuscitation and Education Guidelines** published by the International Federation (IFRC) in 2020. They build on the systematic reviews of **ILCOR** (International Liaison Committee on Resuscitation), which publishes its scientific consensus statements every year. In Europe, the **European Resuscitation Council (ERC)** translates this consensus into guidelines, the latest full edition of which dates from 2021 and includes a dedicated first aid chapter. National guidelines (for example those of a ministry of health or a National Society) may adapt these texts to the local context: where they differ, the first aider follows the protocol in which he or she was trained and certified.

What the IFRC means by first aid

The 2020 guidelines define first aid as the immediate help provided to a sick or injured person until professional help arrives, and they explicitly include the psychological dimension and self-help. They stress three principles that underpin this entire course:

- **Evidence first**: a skill is taught only if it is useful and safe. Practices that were once widespread (distant pressure points, routine elevation of a bleeding limb, cervical collars

applied by first aiders, suction of a snakebite) no longer appear in the guidelines, either for lack of proven benefit or because of the risk they carry.

- **Adaptation to context**: the guidelines recognise that professional help may be far away, that equipment may be lacking and that scene hazards may be high. They distinguish what is recommended everywhere from what depends on the resources available.
- **Education as an intervention**: competence declines quickly after training if it is not maintained. Short, frequent refreshers are more effective than long courses spaced several years apart.

The organisation's duty of care

For a humanitarian organisation, first aid capacity is part of its **duty of care** towards its staff and, in many cases, towards the people it assists at its sites. The Core Humanitarian Standard (CHS), in Commitment 8, requires that staff are supported and that their safety and well-being are taken into account. The Global Interagency Security Forum (GISF) guides on security risk management build the medical plan and medical evacuation into the security plan. In practice, an auditor or security manager will check:

- that there is an up-to-date **medical plan** for each base, known to the teams;
- that the number of trained first aiders is sufficient for every movement and every site to have at least one trained person present (labour law in some countries sets a ratio; otherwise, the organisation defines one according to risk);
- that certificates are valid and refresher training is scheduled at the interval set by the certifying body;
- that kits are complete, checked and restocked after use;
- that every medical incident is reported and followed by a lessons-learned review.

The first aider's limits

The first aider acts **within the limits of his or her training**. He or she does not diagnose, does not prescribe, and does not administer medication except where the protocol explicitly allows it (for example helping a person use their own adrenaline auto-injector, or take sugar in case of hypoglycaemia). The first aider obtains the **consent** of a conscious casualty: a person with capacity may refuse help, and that refusal is respected, explained, and recorded with a witness if possible. For an unresponsive casualty, consent is implied. For a minor, the parent or responsible adult is sought, without delaying a life-saving action.

The legal framework for bystander intervention varies from one country to another: some countries impose a duty to rescue, others explicitly protect the first aider acting in good faith (Good Samaritan provisions). The organisation must know the rule in the country of operation and include it in its briefing. In all cases, an action consistent with the training received and carried out in good faith is the best protection.

> Rule of conduct: do what you have been taught, do not do what you have not mastered, and never delay calling for help in order to perform a secondary action.

Neutrality and non-discrimination

In conflict settings, a humanitarian organisation's first aider provides care on the basis of medical urgency alone, without distinction of affiliation, ethnicity, religion or side. This principle, derived from international humanitarian law and the Fundamental Principles of the Movement, is also a security condition: a team perceived as partial becomes a target. It applies to triage (day 4) just as much as to a simple assessment.

The full assessment step by step: primary survey, secondary survey and monitoring

The assessment presented in the previous sections (response, catastrophic bleeding, airway, breathing) makes up the **primary survey**: it looks for what kills within minutes. When the casualty shows no immediate life-threatening condition, or once that condition has been managed, the first aider carries out a **secondary survey**, followed by continuous **monitoring**. In settings where evacuation takes several hours, it is often the quality of this monitoring and of its handover that makes the difference.

Step 1: the approach and general impression (first few seconds)

While approaching, after checking for safety, the first aider observes: is the casualty moving or talking, what colour is he or she, is there blood on the ground, what is the body position, and what is the likely mechanism of injury (fall from height, vehicle impact, explosion, collapse without trauma)? The mechanism guides what follows: a violent impact calls for limiting movement of the head and neck; a collapse in an older person points to a cardiac cause or a stroke.

Step 2: the structured primary survey

Recent guidance, such as the WHO and ICRC Basic Emergency Care approach, places **catastrophic bleeding** at the top of the sequence, before the airway. The following sequence, adapted to the first aider's level, can be used:

Step	Question	What you do
Catastrophic bleeding	Is there heavy bleeding, spurting, or rapidly soaking the clothing?	Immediate direct pressure, or a tourniquet on a limb (day 2).
Response	Does the casualty respond to voice or touch?	If not: shout for help and get someone to call for assistance.
Airway	Can air get through?	Head tilt and chin lift; remove a visible foreign body only if it is easily reachable.
Breathing	Is the casualty breathing normally? (no more than 10 seconds)	No, or abnormal: CPR and defibrillator. Yes: recovery position if unresponsive.
Circulation	Signs of shock? Other bleeding?	Lay the casualty down, cover, apply pressure to non-catastrophic bleeding.
Disability (level of consciousness)	Is the casualty oriented, confused, drowsy?	Record the level of consciousness and the time.
Exposure and environment	Hidden injuries? Risk of cold or heat?	Look under the clothing while respecting dignity; protect from the ground, sun and rain.

To describe the level of consciousness simply and in a form that can be handed over, many services use the **AVPU** scale: the casualty is **A**lert (awake, eyes open), responds to **V**oice, responds only to **P**ain, or is **U**nresponsive. Any deterioration from one level to another is essential information that must be passed on immediately.

Step 3: the secondary survey

The secondary survey has two components, which can be carried out in parallel if two first aiders are present.

History-taking, from the casualty or witnesses. A widely used memory aid is the acronym SAMPLE:

- **S**igns and symptoms: what do you feel, where does it hurt, since when?
- **A**llergies known.
- **M**edications taken regularly (heart, epilepsy or diabetes treatment, anticoagulants).
- **P**ast medical history: known conditions, pregnancy, recent surgery.
- **L**ast meal: last food and drink (useful if surgery is likely).
- **E**vents: what exactly happened, and in what order?

The head-to-toe examination, wearing gloves and explaining each action: head and face (wounds, bleeding from the nose or ears), neck (pain, deformity), chest (symmetrical movement, wounds), abdomen (pain, rigidity), pelvis (without compressing or moving it), limbs (deformity, wounds, movement, sensation and colour of the extremities), and the back if the casualty can be examined without being moved unnecessarily.

Step 4: vital signs a first aider can observe

Without medical equipment, the first aider can measure and record:

- **Respiratory rate**: count chest movements for 30 seconds and multiply by two, or for a full minute in a child. In an adult at rest, a normal rate is around 12 to 20 per minute. For children, the WHO and UNICEF Integrated Management of Childhood Illness (IMCI) strategy defines fast breathing as: 60 per minute or more under 2 months, 50 or more from 2 to 12 months, 40 or more from 1 to 5 years.
- **Pulse**, at the wrist (radial) or neck (carotid): fast or slow, regular or not, strong or weak. In an unresponsive casualty, a pulse check is **not** used by a first aider to decide whether to start CPR: it is the absence of normal breathing that counts.
- **Skin**: colour (pale, grey, bluish), temperature, sweating.
- **Level of consciousness** (AVPU) and orientation (name, place, day).
- **Pain**, on a simple 0 to 10 scale if the casualty can answer.

Step 5: monitoring and record-keeping

A seriously ill or injured casualty is reassessed continuously; a stable casualty at least every 5 to 15 minutes depending on severity and the local protocol. Each reassessment is recorded with the time. The first aider also records every action taken (time a tourniquet was applied, start of CPR, number of shocks delivered by the defibrillator). This sheet travels with the casualty and is handed to the medical team taking over care.

> If it is not written down, it was not done. A simple, time-stamped monitoring sheet handed to the medical team is worth more than a long verbal account given amid the noise of an emergency department.

Alerting, MEDEVAC and CASEVAC: building the field chain of care

In a country with a functioning emergency service, raising the alarm means dialling a number. In most humanitarian settings, the chain of care has to be **built in advance** by the organisation. Without a prepared plan, the time lost finding a vehicle, a facility able to operate, or movement clearance often exceeds the time the casualty can survive.

Terminology

- **CASEVAC** (casualty evacuation): transport of an injured or sick person by non-medical means (organisation vehicle, pick-up, boat), usually to the nearest health facility.
- **MEDEVAC** (medical evacuation): evacuation with medical escort (equipped ambulance, air ambulance), often organised by an assistance company or by the medical service of the organisation or of the United Nations.
- **Referral facility**: a health facility whose level of care is known in advance (health post, health centre, district hospital with an operating theatre, referral hospital with intensive care and a blood bank).

Building a base medical plan: an eight-step method

1. **Map the facilities** within a relevant radius: name, level, surgical capacity, availability of blood transfusion, a defibrillator, antivenom and rabies vaccine; opening hours; direct contact of a manager. Visit the facilities rather than relying on an old list.
2. **Measure actual travel times** by day and by night, in the dry season and the rainy season, taking account of checkpoints and curfew hours.
3. **Define the means of transport**: available vehicles, whether a casualty can lie flat in the back, boats, agreement with a humanitarian air operator (for example the United Nations Humanitarian Air Service where it operates) and its conditions for accepting a sick passenger.
4. **Identify the decision-makers**: who triggers an evacuation (head of base, security focal point, medical adviser), who approves expenditure, who contacts the assistance company and with what information (insurance policy number, passport, blood group if known).
5. **Set up communications**: verified phone numbers and radio channels, satellite phone, call signs, procedure if the network goes down.
6. **Prepare the documents**: an emergency information form for each staff member (contacts, allergies, medication, blood group if the person agrees to share it), kept confidential and accessible only to the designated manager.
7. **Pre-position the equipment**: basic kits and a trauma kit, a post-exposure prophylaxis (PEP) kit in line with the organisation's policy, survival blankets, a folding stretcher, a water reserve.
8. **Test the plan**: an exercise at least once a year and at each major team rotation, with real timing between the call and arrival at the facility.

The enhanced alert message

The basic message (where, what, condition, who) remains the rule. For an evacuation request by radio to the base or the medical focal point, the information the decision-makers need is added. The template below is inspired by the evacuation request formats used by organisations and United Nations missions, simplified for civilian use.

Line	Content	Example
1. Location	GPS coordinates, landmark, accessibility	Kalo–Mira track, km 34, concrete bridge, accessible by 4x4
2. Caller	Name, call sign, call-back means	Team Alpha 2, channel 5, satellite 0 0 00 00 00 (fictitious number)
3. Number and severity	How many casualties, how many in life-threatening condition	2 casualties: 1 serious, 1 minor
4. Condition of each casualty	Response, breathing, bleeding, AVPU, trend	Adult male, responds to pain only, breathing, no haemorrhage
5. Care given	With times	Recovery position at 10:42, monitoring every 5 minutes
6. Requirements	Stretcher transport, equipment, escort	Vehicle for lying-down transport, request for medical advice
7. Security	Situation on site, threats	Calm, crowd of about twenty people, no threat
8. Proposed destination	Appropriate facility and travel time	Mira district hospital (operating theatre), 1 h 20 min

Deciding between waiting and evacuating by your own means

The general principle is simple: when a competent emergency service can arrive within a reasonable time, you wait and monitor. When that is not the case, the organisation decides to transport the casualty by its own means. The criteria weighing on the decision are the severity and trend of the casualty's condition, the real distance to a facility able to treat the problem (a bleeding casualty needs an operating theatre, not a health post), the security of the route and the time of day, and whether the casualty can be transported lying down and monitored. The decision is taken by the person designated in the plan, after remote medical advice if possible, and recorded with the time.

> The fastest transport is not always to the nearest facility: a health post without a surgeon wastes time for a casualty who needs an operation. That is why the level of each facility must be known before the incident.

Worked example: road traffic accident on an isolated track

Fictitious context: the NGO "Horizons Partagés" runs a water, sanitation and hygiene programme in Morelle district. A team of three (an engineer, a community mobiliser and a driver) is returning from a village 2 h 30 min from Kalo base. The mobiliser and the driver have held first aid certification for eight months; the engineer did a refresher two years ago. The vehicle carries a basic kit, a commercial tourniquet, two survival blankets, an HF radio and a satellite phone. The base medical plan designates Mira district hospital (operating theatre, no intensive care) at 1 h 20 min and Tobé health centre (nurse, no surgery) at 25 minutes.

Timeline

Time	Situation	Decision and reasoning
10:38	A motorbike has hit a stationary truck. The motorcyclist is on the ground, motionless; a female passenger is sitting up, holding her forearm and crying. The truck is leaking fuel.	The driver stops the vehicle at a distance, hazard lights on, engine off. He asks the truck driver to switch off the ignition and forbids smoking. Hazards identified: fuel and traffic. A villager is asked to warn approaching vehicles of the accident.
10:40	The mobiliser approaches the motorcyclist from the side, talking to him. No response to voice. Gloves on.	No visible catastrophic bleeding. He keeps the head in line without removing the helmet, opens the airway and looks, listens and feels: breathing present, regular, about 16 per minute.
10:41	The engineer attends to the passenger, who is talking and answering appropriately.	She introduces herself, asks for consent, notes a deformity of the forearm without a wound. She has the casualty support the arm herself in the least painful position.
10:42	The motorcyclist is breathing but responds only to pain (level P). He starts making gurgling sounds.	Risk of aspirating blood or vomit: he is placed in the recovery position by two first aiders, keeping head and neck movement to a minimum. The full-face helmet with a split visor is in the way: it is removed only by two people, using the technique learned, because the airway is under threat.
10:45	The driver calls the base by radio.	Complete message: location (Kalo–Mira track, km 34), two casualties, one serious (responds to pain, breathing, gurgling, placed on his side), one less serious (probable forearm fracture), scene secured, request for medical advice and an evacuation decision.
10:52	The medical adviser, reached by satellite phone, recommends Mira hospital: a head injury with altered consciousness requires a facility able to operate and monitor.	Tobé health centre, although closer, is ruled out for the motorcyclist. The base alerts Mira hospital. The head of base authorises transport in the organisation's vehicle, since an ambulance is estimated to be more than two hours away.
11:00	Preparing for transport.	The motorcyclist is placed lying on his side on the adapted back seat and covered; the mobiliser travels with him to monitor. The passenger, with an improvised sling, sits in the front. The motorcyclist's brother, who has arrived on scene, is informed and comes along.
12:22	Arrival at Mira hospital.	The monitoring sheet and a structured verbal handover are given to the nurse on duty. Soiled gloves and waste are disposed of at the hospital.

The completed monitoring sheet (motorcyclist)

Time	Consciousness (AVPU)	Breathing (per minute, quality)	Radial pulse	Skin	Actions and remarks
10:40	U then P	16, regular	Palpable, fast	Pale	Airway opened, head held in line
10:42	P	18, gurgling	Palpable	Pale	Recovery position, helmet removed by two people
10:50	P	18, quieter	Palpable	Pale, cool	Single episode of vomiting, mouth cleared, blanket
11:05	V	16, regular	Palpable	Pale	Opens eyes when called, agitated, confused speech
11:35	V	16	Palpable	Pale	No further vomiting
12:05	P	14	Palpable, slower	Pale	Deterioration in consciousness reported by radio, hospital alerted

Post-incident review

- **What worked**: the scene was secured before any contact; roles were assigned immediately; the radio message was complete; the destination decision was based on the level of the facility rather than the distance; time-stamped monitoring made it possible to report the deterioration at 12:05.
- **What needs to improve**: the engineer's refresher training was out of date and she did not feel confident; the kit contained no splint or sling material; the Mira hospital number in the medical plan was no longer valid and the base lost five minutes finding it.
- **Actions agreed**: refresher training for all field staff before the end of the quarter; malleable splints and triangular bandages added to all vehicle kits; monthly check of the medical plan numbers by the security focal point; incident report sent to headquarters within 24 hours in line with procedure.

> The decisive point in this example is not a technical skill: it is the combination of a secured scene, a structured alert and a destination decision based on prior knowledge of the facilities. That is exactly what the medical plan must make possible.

Reusable tools: checklists and field sheets

The following tools are designed to be printed, laminated and kept in vehicles, offices and kits. They must be adapted to the protocol of the body that certified your first aiders and validated by your organisation's medical adviser.

Checklist 1: scene safety (before any contact)

- Traffic: vehicle parked safely, hazard lights on, warning signs placed upstream and downstream.
- Fire, fuel, gas: ignition off, no smoking, fire extinguisher within reach.
- Electricity: cables on the ground, damaged installations; do not touch the casualty until the power is cut.
- Structure: cracked building, unstable wall, risk of collapse.
- Environment: flood water, slopes, animals, extreme heat.
- Human threat: hostile crowd, armed presence, risk of a secondary explosion, unexploded ordnance.
- Biological and chemical hazards: blood, body fluids, unusual smell, several casualties with no apparent injury (think of mass poisoning).
- Personal protection: gloves, eye protection if splashes are possible, pocket mask for rescue breaths.

Checklist 2: minimum content of the base medical plan

Item	In place	Date checked	Person responsible
List of health facilities with level, capacities and verified contacts			
Travel times by day, by night and in the rainy season			
Evacuation decision procedure and names of decision-makers			
Assistance company contact details and policy numbers			
Confidential individual emergency information forms			
List of certified first aiders and expiry dates			
Kit inventory and expiry dates			
Blood exposure procedure and access to post-exposure prophylaxis			
Date of the last exercise and main findings			

Sheet 3: assessment and handover (one page)

Heading	What to record
Identification	Sex, estimated age, name if known, accompanying person
Circumstances	Time, mechanism (fall, impact, collapse, explosion), position found in
Primary survey	Catastrophic bleeding, response, airway, breathing, signs of shock
History	Complaints, allergies, medication, past history, last meal, sequence of events
Examination	Injuries found from head to toe
Care given	Nature and time of each action (tourniquet, position, CPR, shocks)
Monitoring	Time-stamped table: consciousness, breathing, pulse, skin, pain
Handover	Name of the person and facility that took over, time

Sheet 4: verbal handover to the medical team

An effective verbal handover takes less than a minute and follows a fixed order, inspired by the structured formats used in hospitals:

1. Who the casualty is (age, sex) and what happened (mechanism, time).
2. What was found (injuries and life-threatening problems).
3. What was done (actions, times).
4. How the condition has changed (improvement, stable, deterioration).
5. What concerns the first aider and any outstanding questions (for example: unknown medication, possible allergy).

Checklist 5: after the intervention

- Disposal of soiled waste and gloves in an appropriate container.
- Hand washing; in case of blood exposure, immediate application of the exposure procedure.
- Incident report in line with the organisation's procedure, within the set deadlines.
- Restocking of the kit used, on the same day.
- Debriefing with those involved and offer of support if needed (day 3 and day 4).

Common mistakes, contextual variations and what auditors look for

The most common mistakes in the field

Mistake	Consequence	How to avoid it
Rushing to the casualty without looking at the scene	First aider injured (traffic, electricity, secondary explosion)	Force yourself to pause for a few seconds; make scene safety a reflex drilled in exercises.
Delaying the alert to perform first aid	Help arrives too late	Have a bystander raise the alarm immediately, giving them a precise message to pass on, and ask them to come back and confirm.
Mistaking agonal gasps for normal breathing	CPR not started	Remember that infrequent, noisy, irregular breathing in an unresponsive casualty is a sign of cardiac arrest.
Checking for a pulse to decide on CPR	Time lost; a frequent error even among health professionals	Base the decision on response and breathing, as the guidelines for first aiders require.
Incomplete alert message	Call-backs, wrong destination, wrong resources sent	Use an alert card displayed in vehicles; practise the message in exercises.
Evacuating to the nearest facility by default	Secondary transfer, hours lost	Know the level of the facilities before the incident.
Recording nothing	The medical team does not know the tourniquet time or the deterioration	A monitoring sheet in every kit, or write the application time directly on the skin or the tourniquet with a marker.
Incomplete or expired kit	Care impossible on the day it is needed	Signed monthly check, restocking on the day of use.
Expired certificates	Loss of confidence and competence, compliance problem	Expiry tracking table kept by human resources or security.

Contextual variations

Sudden-onset crisis (earthquake, flood, cyclone): health facilities are themselves affected, roads are cut off and communications are saturated. Pre-established medical plans must be re-verified in the first hours; teams need greater self-sufficiency in equipment. Scene hazards (aftershocks, weakened buildings, contaminated water) predominate.

Protracted crisis: the main risk is routine. Kits run down, phone numbers change, trained staff leave and are not replaced. A schedule of checks and exercises is essential.

Camp or displacement site: high population density, many bystanders, crowds gather quickly. Health partners present on site (clinics, mobile teams) must be included in the plan, with their opening hours. Community volunteers trained in first aid are a major asset.

Urban settings: public emergency services often exist but may be overwhelmed or unable to access certain neighbourhoods. Traffic can make transport slower than in rural areas. Electrical,

fire and collapse hazards are more frequent.

Remote management: when international staff cannot travel to the field, responsibility for first aid rests with national staff and partners. The organisation must fund their training and equipment to the same standard, and guarantee them the same access to evacuation and insurance. Unequal treatment between categories of staff in terms of security and care is a breach of duty of care that auditors will flag.

High insecurity: night movements may be prohibited, roads closed, checkpoints slow. The plan must provide for prolonged care on site (several hours), alternative routes, and safe-passage agreements for medical evacuations. The ICRC and National Societies are often the only actors able to negotiate such passage.

Local partners with limited capacity: first aid training is a concrete and valued element of capacity strengthening. It must be budgeted in proposals (certified training, kits, refreshers) rather than left for the partner to cover.

What auditors, donors and insurers look for

- Existence and updating of the medical plan and the security plan, and evidence that they have been shared with teams.
- Training register with certification and refresher dates, broken down by staff category and by partner.
- Medical incident reports and lessons-learned reviews, and evidence that the agreed actions have been implemented.
- Signed and dated kit checks.
- Consistency between the budget (training and equipment lines) and reality on the ground.
- Equal treatment of national staff, international staff and partners.

Interview questions and key references

The following questions are frequently asked in interviews for security focal point, head of base, field coordinator, logistician or health manager positions. The answer guidance indicates what a panel expects from an experienced candidate.

1. "You are first on the scene of a road traffic accident with two casualties. Describe your first few minutes."

A strong answer starts with scene safety (vehicle parked, hazard lights, fuel, traffic), then assigning roles, early alerting by a third party, the primary survey beginning with catastrophic bleeding, the decision on positioning based on response and breathing, and time-stamped monitoring. It mentions limiting head and neck movement in case of violent trauma, and a structured handover.

2. "How do you build a medical plan for a new base?"

The candidate mentions mapping and visiting facilities to establish their actual level of care, travel times by time of day and season, decision-makers, communications, confidential individual forms, equipment, coordination with the assistance company, and testing through a timed exercise. He or she refers to regular updating and to the inclusion of partners.

3. "How do you decide between waiting for an ambulance and transporting a casualty yourself?"

The candidate sets out the criteria: severity and trend, the real response time of emergency services, the distance to a facility able to treat the problem, route security, whether the casualty can be transported lying down and monitored, and remote medical advice. He or she specifies that the decision lies with the person designated in the plan and that it is recorded.

4. "A member of your team refuses to be evacuated after collapsing. What do you do?"

The candidate assesses the person's capacity to decide (consciousness, orientation), explains the risks, seeks medical advice, respects an informed refusal, documents it with a witness, arranges monitoring and reassessment, and informs line management in line with procedure. He or she distinguishes this case from that of a confused person whose decision-making capacity is impaired.

5. "How do you ensure duty of care towards national staff and partners under remote management?"

The candidate talks about equal access to training, equipment, insurance and evacuation, dedicated budget lines, tracking of certifications, and the need to consult the staff concerned about the risks they consider most important.

6. "Which international guidelines govern first aid, and what do you do if they differ from the national protocol?"

The candidate cites the 2020 IFRC guidelines, the ILCOR consensus statements and the ERC guidelines, and explains that the first aider applies the protocol in which he or she is certified, while the organisation ensures that its training remains consistent with current guidelines.

Key references

- *International First Aid, Resuscitation and Education Guidelines* (2020): International Federation of Red Cross and Red Crescent Societies (IFRC), with its Global First Aid Reference Centre.
- *International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations*: International Liaison Committee on Resuscitation (ILCOR), published annually.
- *European Resuscitation Council Guidelines* (2021), in particular the chapters on basic life support and first aid: European Resuscitation Council.
- *Basic Emergency Care: approach to the acutely ill and injured*: World Health Organization and International Committee of the Red Cross.
- *First Aid in Armed Conflicts and Other Situations of Violence*: International Committee of the Red Cross.
- *The Sphere Handbook* (2018), Health chapter: Sphere Association.
- *Core Humanitarian Standard on Quality and Accountability* (CHS), Commitment 8: CHS Alliance, Groupe URD and Sphere.

- *Security Risk Management: a basic guide for smaller NGOs* and related guides: Global Interagency Security Forum (GISF).
- Integrated Management of Childhood Illness (IMCI) strategy: WHO and UNICEF.

> Reminder: this online course does not replace certified hands-on first aid training. Enrol in a course with the Red Cross, the Red Crescent or an accredited provider, and keep your skills up to date through regular refresher training.

Exercise: your emergency sheet

For your workplace, fill in a one-page sheet: emergency numbers that actually work, the nearest health facility and its level (health post, hospital with surgery), travel time by day and by night, the location of the first aid kit and the PEP kit, and your organisation's MEDEVAC procedure. Post it up and keep a copy in every vehicle.

Key takeaways

- Protect, alert, assist: always in that order.
- Scene safety first, including the risk of a second explosion.
- Gloves and hand hygiene; exposure to blood: PEP within 72 hours.
- Assessment: response, catastrophic bleeding, airway, breathing (10 seconds at most).
- Alert: where, what, condition, who; do not hang up first.

Quiz

1. What is the first action when you arrive at an accident?
   A. Take a photo for the report
   B. Touch the casualty to reassure them
   C. Give the casualty something to drink
   D. Check that the scene is safe for yourself, the casualty and bystanders
2. An unresponsive casualty is taking infrequent, noisy breaths (gasps). They are:
   A. To be sat up
   B. Sleeping deeply
   C. Not breathing normally: call for help and start resuscitation
   D. Breathing normally

3. In an alert message, you first give:
   A. Your full name
   B. The exact location of the accident
   C. The organisation's name
   D. The time the mission left

Quiz answers : 1. B · 2. B · 3. B

Day 2 : Life-threatening emergencies: cardiac arrest, choking, bleeding

Objectives

- Perform cardiopulmonary resuscitation and use a defibrillator.
- Place a casualty in the recovery position and relieve choking.
- Stop severe bleeding and recognise shock.

Cardiac arrest: cardiopulmonary resuscitation

A casualty who is unresponsive and not breathing normally is in **cardiac arrest**. Every minute without chest compressions sharply reduces their chances of survival.

- Casualty on their back, on a firm surface. Hands one on top of the other in the **centre of the chest**.
- Compressions **5 to 6 cm** deep in adults, at a rate of **100 to 120 per minute**, letting the chest rise fully.
- If you are trained and willing: **30 compressions then 2 rescue breaths**. Otherwise, continuous compression-only CPR is already very useful.
- Continue until help arrives, normal breathing returns or you are exhausted; swap every two minutes if there are several of you.

Child: one or two hands, about one third of the depth of the chest. **Infant**: two fingers, about 4 cm. In children, arrest is often caused by breathing problems: rescue breaths are important if you are trained.

The defibrillator and the recovery position

An **automated external defibrillator (AED)** analyses the heart rhythm and delivers a shock if needed. Switch it on and follow the voice prompts; attach the pads to the bare, dry chest; nobody touches the casualty during analysis and shock; resume compressions as soon as the device tells you to. Find out in advance whether your office, the airport or the nearby hospital has one.

A casualty who is **unresponsive but breathing normally** is placed in the **recovery position**: on their side, head tilted back, mouth pointing down so that vomit can drain. Check their breathing regularly: if it stops, roll them onto their back and start resuscitation.

Choking: clearing the airway

A foreign body (food, small object) can block the airway.

- **Mild obstruction**: the person coughs, speaks, breathes. Encourage them to cough and do nothing else.

- **Severe obstruction**: they cannot speak, cough effectively or breathe, and often clutch their throat. Give **5 back blows** between the shoulder blades with the person leaning forward; if unsuccessful, give **5 abdominal thrusts** (fist just above the navel, pull inwards and upwards). Alternate 5 and 5.
- **Infant**: 5 back blows, face down along your forearm with the head lower, then 5 chest thrusts with two fingers. No abdominal thrusts.
- If the casualty becomes unresponsive: call for help and start resuscitation.

Severe bleeding and shock

Catastrophic bleeding can kill within minutes. Gloves if possible, then firm **direct pressure** on the wound, with your hand or a thick dressing; do not release it to look. Add more dressings on top if blood soaks through.

If direct pressure is not enough or not possible on a limb (amputation, several casualties, inaccessible wound), apply a **tourniquet**: 5 to 7 cm above the wound, never over a joint, tightened until the bleeding stops. **Write down the time** it was applied and never loosen it yourself. An improvised tourniquet (wide strip of cloth and a stick) is less effective than a commercial one: field vehicles should carry one.

Shock (pale, cold, clammy skin, rapid pulse, agitation then drowsiness) often follows bleeding: lay the casualty down, cover them, reassure them, give nothing to eat or drink and monitor them until evacuation.

The chain of survival and high-quality CPR: what really makes the difference

> Resuscitation, choking relief and bleeding control cannot be learned by reading. This online course prepares for and complements certified hands-on training, with manikin practice and assessment by an instructor; it does not replace it. Guidelines change: check that your training follows the current version of the IFRC and European Resuscitation Council guidelines, or the equivalent national protocol.

International guidelines describe the management of cardiac arrest as a **chain of survival**: early recognition and call for help, early cardiopulmonary resuscitation (CPR) by bystanders, early defibrillation, advanced life support, and then post-resuscitation care. In humanitarian settings, the last two links are often absent or far away. This does not make CPR pointless, but it changes its role: the bystander and the defibrillator carry almost all of the chance of survival, and teams need to be told this honestly.

Recognising cardiac arrest without hesitation

The ERC and IFRC guidelines use two simple criteria for a first aider: the casualty is **unresponsive** and is **not breathing normally**. Checking for a pulse is not taught to first aiders for this decision. Two pitfalls are common:

- **Agonal gasps**: slow, deep or noisy agonal breaths, present in the first minutes in many casualties. They must be interpreted as an absence of normal breathing.

- **Seizure-like movements** at the moment of arrest: a brief seizure-like episode may accompany the arrest. Once it is over, check breathing; if it is not normal, start CPR.

Where an emergency service can be reached, the guidelines stress calling early, with the phone on speaker, so that the dispatcher can guide the bystander. In a setting without an emergency service, the equivalent is immediately alerting the medical focal point or the referral facility, and sending someone to fetch the defibrillator if there is one.

The determinants of effective CPR

Parameter	Recommendation in adults	Common error
Hand position	In the centre of the chest, on the lower half of the sternum	Hands too low, on the stomach, or off-centre on the ribs
Depth	5 to 6 cm	Compressions too shallow, especially as fatigue sets in
Rate	100 to 120 per minute	Rate too fast under stress
Recoil	Allow the chest to rise fully between compressions	Leaning on the chest
Interruptions	Keep them to a minimum; the two rescue breaths should not interrupt compressions for more than a few seconds	Long pauses to check, discuss or swap places
Rescue breaths	Each lasts about one second, with visible chest rise	Breaths too forceful or too long, inflating the stomach
Rotation	Change rescuer about every two minutes	A single rescuer becoming exhausted without saying so
Surface	Casualty on a firm surface	Compressions on a soft mattress

The guidelines accept that untrained bystanders, or trained ones who are unwilling or unable to give rescue breaths, perform continuous **compression-only CPR**. For trained people, the sequence of 30 compressions and 2 rescue breaths remains the standard in adults. A pocket mask with a one-way valve protects the rescuer and should be included in every kit.

Children and infants

In children, cardiac arrest is most often the consequence of respiratory failure (drowning, choking, severe respiratory infection, severe dehydration). This is why the ERC paediatric guidelines provide that people trained in paediatric life support start with **5 initial rescue breaths**, then alternate compressions and breaths at the ratio taught in their paediatric training. The guidelines specify that a bystander trained only in adult CPR should apply what he or she knows rather than do nothing: imperfect CPR is far better than no CPR at all.

- Depth: at least one third of the depth of the chest (about 4 cm in an infant, about 5 cm in a child).

- Technique: two fingers or two encircling thumbs in an infant; one or two hands in a child, depending on size.
- Rate: 100 to 120 per minute, as in adults.

When not to start, when to stop

A first aider does not start CPR when there are obvious signs of death that occurred some time ago or injuries clearly incompatible with life, or when the scene is dangerous. He or she stops when a professional takes over, when the casualty shows signs of life (movement, eye opening, normal breathing), when exhausted, or when the scene becomes dangerous. In isolated settings, the question arises of how long it is reasonable to continue CPR without a defibrillator or backup; the decision rests on medical advice, obtained remotely if possible, and on the organisation's protocol. The first aider must not carry this decision alone.

Team resuscitation and defibrillation: roles, timing and special circumstances

When several people are present, the quality of CPR depends more on organisation than on individual technique. Humanitarian teams, often gathered in an office, at a distribution site or in a base camp, can practise a simple allocation of roles.

Allocation of roles

Role	Tasks	Who
Team leader	Checks the scene, assigns roles, monitors quality (depth, rate, recoil), calls the changeover every two minutes, records times	The most experienced first aider, who does not do compressions personally while others can
Rescuer 1	Chest compressions	Trained first aider
Rescuer 2	Rescue breaths with a mask if trained; takes over compressions	Trained first aider
Alert	Calls the emergency service or the medical focal point, comes back to confirm, guides the responders in at the entrance	Any reliable person
Defibrillator	Fetches the AED and the kit, runs back, switches the device on	Someone who knows where it is kept
Bystander management	Keeps the crowd back, protects the casualty's dignity, informs relatives	A calm person, ideally one who speaks the local language

Using the automated external defibrillator: detailed sequence

1. As soon as the device arrives, **switch it on** and follow the voice prompts. Compressions continue in the meantime.
2. **Bare the chest**. Dry it quickly if wet; quickly shave or remove hair if the device contains a razor and the pads do not stick; remove any visible medication patch where a pad needs to

go.

3. **Attach the pads** as shown in the diagram: generally one below the right collarbone and the other on the left side of the chest, below the armpit. Avoid placing them directly over an implanted device visible under the skin (pacemaker).
4. **During analysis**, nobody touches the casualty. The team leader clearly calls everyone to stand clear.
5. **If a shock is advised**, check that nobody is touching the casualty, then press the button (or let the device deliver it if it is fully automatic). Resume compressions immediately, without waiting or checking breathing.
6. **If no shock is advised**, resume compressions immediately. The absence of a shock does not mean the casualty is improving.
7. Continue following the device's prompts; it re-analyses at regular intervals. **Do not remove the pads**, even if the casualty resumes normal breathing.

For a child, use paediatric pads or the paediatric mode if the device has one; failing that, the guidelines accept the use of adult pads, placed so that they do not touch each other (for example one on the front and one on the back).

Special circumstances

- **Drowning**: the arrest is respiratory in origin. The guidelines provide that a trained rescuer starts with **5 rescue breaths** before compressions. Do not enter the water without water rescue training: reach, throw, don't go.
- **Advanced pregnancy**: CPR is performed in the same way. Specialist guidelines provide that, when a second rescuer is available and the uterus is visibly enlarged, it should be manually displaced to the left to improve blood return to the heart.
- **Trauma**: traumatic cardiac arrest has specific causes (haemorrhage, airway obstruction). The first aider first controls catastrophic bleeding, then performs CPR.
- **Opioid poisoning**: in programmes that authorise it, trained first aiders may administer naloxone. This does not replace either the alert or CPR.
- **Electrical injury**: cut off the power before any contact.
- **Epidemic of a respiratory-transmitted disease**: guidance published during the COVID-19 pandemic advised bystanders to favour compression-only CPR and to cover the casualty's mouth and nose with a cloth. Follow the guidance in force at the time of the epidemic.

Warning signs that precede cardiac arrest

Some cardiac arrests are preceded by signs that allow earlier action.

- **Chest pain suggestive of a heart attack**: pain or tightness in the centre of the chest, possibly radiating to the arm, jaw or back, with sweating, nausea, shortness of breath. Have the person rest in the position they find most comfortable, raise the alarm immediately, and, if the organisation's protocol and training allow it and there is no known allergy or contraindication, have a conscious adult chew aspirin, as permitted by the European first aid guidelines. Get the defibrillator ready.

- **Stroke**: facial asymmetry, weakness in one arm, speech disturbance, of sudden onset. The FAST tool (Face, Arm, Speech, Time) or an equivalent scale helps to recognise it. Note the time the signs began, raise the alarm, give nothing by mouth.

Choking and bleeding: detailed techniques and points of vigilance

Foreign body airway obstruction

The principle of the guidelines is to recognise the severity, then apply a simple sequence, repeated as needed.

Situation	Adults and children over one year	Infants (under one year)
Effective cough, able to speak	Encourage coughing, stay close, monitor	Monitor, let the infant cough
Ineffective cough, casualty conscious	Up to 5 back blows, leaning forward; then up to 5 abdominal thrusts; alternate	Up to 5 back blows, head lower than the body; then up to 5 two-finger chest thrusts; alternate
Loss of consciousness	Lower to the ground, call for help, start CPR	Call for help, start paediatric CPR

- After each blow or thrust, check whether the obstruction has cleared: there is no need to complete all five.
- Do not perform blind finger sweeps of the mouth; remove only an object that is clearly visible and reachable.
- For a woman in advanced pregnancy or a person whose abdomen cannot be encircled, many programmes teach chest thrusts instead of abdominal thrusts: follow the protocol of your training.
- Anyone who has received abdominal thrusts must be examined by a health professional, because of the risk of internal injury.

Bleeding: the hierarchy of interventions

The 2020 IFRC guidelines and the 2021 ERC guidelines converge on a clear hierarchy:

1. **Direct manual pressure**, firm and continuous, on the wound, with gloves if possible, through a dressing or clean cloth. This is the first action for the vast majority of bleeds.
2. **Haemostatic dressing** (a dressing impregnated with an agent that promotes clotting), when the first aider is trained and the equipment is available, particularly for wounds where a tourniquet cannot be applied.
3. **Tourniquet** for life-threatening bleeding from a limb, when pressure is insufficient or not feasible. A commercial tourniquet is preferable; an improvised tourniquet is recommended only as a last resort, by a first aider trained to make one, because it often fails.

Recent guidelines no longer include limb elevation or proximal pressure on a "pressure point" as bleeding control measures, for lack of evidence of effectiveness.

The tourniquet: technique and pitfalls

- Place it on the limb, above the wound (between the wound and the heart), a few centimetres from it, never over a joint. If the wound is difficult to locate, many combat trauma protocols teach placing it high on the limb.
- Tighten until the **bleeding stops**. An insufficiently tightened tourniquet can increase bleeding by blocking venous return without blocking arterial inflow.
- If bleeding continues despite a correctly tightened tourniquet, a second tourniquet may be applied just above the first, in line with the training received.
- Application is painful: warn the casualty, and do not loosen it to relieve the pain.
- **Record the time** of application visibly (on the tourniquet, on the skin, on the form). Do not cover the tourniquet with clothing or blankets that would hide it from the medical team.
- Only a medical team decides whether to loosen it or convert to another method.

Junctional wounds and wound packing

In junctional areas (groin, armpit, base of the neck), a limb tourniquet is impossible. The trained first aider packs the wound with gauze or a haemostatic dressing, pressing it firmly into the depth of the wound, then applies firm and prolonged pressure. This skill is taught in trauma training courses; it is covered again on day 4.

Shock: monitoring and preventing deterioration

Shock is a failure of the circulation. The first aider cannot treat it, but can prevent it from getting worse: stop the bleeding, lay the casualty down, protect from the cold (insulating blanket underneath and on top), reassure, give nothing to drink or eat, monitor and arrange evacuation. The European guidelines allow the legs of a casualty in shock without trauma to be raised for a limited time; in trauma, the casualty is left flat. Signs to report: pallor, cold sweats, fast and weak pulse, rapid breathing, thirst, agitation followed by drowsiness.

> The order is not up for debate: catastrophic bleeding is treated before anything else. A casualty bleeding heavily from the thigh can die within minutes; neither the alert nor the full assessment should delay pressure or the tourniquet, which can be handed to a guided bystander if the first aider has to raise the alarm.

Worked example: cardiac arrest on the premises of a field office

Fictitious context: the office of the organisation "Solidarité Vallée Verte" in Kalo, 22 employees, located 15 minutes from the regional hospital, which has an emergency department and an ambulance. The office has a defibrillator, bought the previous year following a security audit and kept at reception. Four employees are certified in first aid. The medical plan was exercised three months earlier.

Minute-by-minute timeline

Elapsed time	Event	Action and person responsible
0 min 00 s	During a meeting, Mr T., a 56-year-old accountant, slumps in his chair and then slides to the floor.	Ms A., a certified logistician, checks the scene (no hazard), and tries to rouse him by voice and by tapping his shoulders: no response.
0 min 15 s	She tilts the head back, lifts the chin and checks breathing: two slow, noisy movements in ten seconds.	She recognises agonal gasps. She names a colleague: "Karim, call the hospital, say cardiac arrest at the office, put it on speaker and come back"; and another: "Lina, the defibrillator at reception, run."
0 min 30 s	Ms A. starts compressions.	The casualty is lying on the tiled floor. Rate counted out loud.
1 min 10 s	Mr B., a second certified first aider, arrives with the pocket mask from the kit.	He positions himself at the head. The sequence of 30 compressions and 2 rescue breaths begins. Ms A. also gives him the role of timekeeper.
1 min 40 s	The defibrillator arrives.	Lina switches it on. Compressions continue while Mr B. bares and dries the chest and attaches the pads.
2 min 05 s	Analysis: shock advised.	Ms A. calls everyone to stand clear, checks visually, delivers the shock. Compressions resume immediately.
2 min 10 s	Karim confirms that the ambulance has left, with an announced arrival time of 12 minutes.	The team leader asks Karim to go and meet the ambulance at the gate and another colleague to clear the corridor.
4 min 05 s	Second analysis: shock advised.	Changeover on compressions (Mr B. compresses, Ms A. moves to the head). Shock delivered, immediate resumption.
6 min 05 s	Third analysis: no shock advised.	Compressions resume.
6 min 40 s	The casualty moves an arm and breathes more regularly.	Compressions stopped, breathing checked: normal. Casualty placed in the recovery position, pads left in place, defibrillator left on.
13 min 30 s	The ambulance arrives.	Handover by Ms A. with the time-stamped sheet: time of collapse, start of CPR, number and times of shocks, return of breathing, regular medication reported by a colleague.

Why this outcome was possible

- **Time from collapse to compressions**: 30 seconds, thanks to immediate recognition of agonal gasps.

- **Time to first shock**: about 2 minutes, because the device was less than a minute's run away and everyone knew where it was.
- **Instructions given by name**: "Karim, call" is more effective than "somebody call".
- **Limited interruptions**: pads attached during compressions, immediate resumption after the shock.
- **Record-keeping**: the timekeeper noted the times, allowing a complete handover.

The same situation at an isolated base

If the same casualty collapses at a base four hours from the nearest hospital, without a defibrillator, the chances of survival are much lower. High-quality CPR must nevertheless be started immediately, the alarm raised and medical advice sought. This gap illustrates two management decisions: purchasing defibrillators for bases with large numbers of staff or staff exposed to cardiovascular risk, and taking medical history into account during pre-deployment medical checks, while respecting confidentiality.

A second short case: bleeding at a distribution point

During a distribution, a crowd surge knocks a man onto a sheet of corrugated iron. Deep wound on the inner thigh, heavy and continuous bleeding. The first aider immediately applies pressure with both hands over a thick dressing, putting his full weight on it, then asks for the tourniquet from the kit. Pressure is not enough: blood soaks through quickly. He applies the commercial tourniquet to the thigh above the wound, tightens it until the bleeding stops, writes the time with a marker on the tourniquet and on the form, lays the casualty down, covers him, and has the on-site health partner alerted, who arranges transfer to the hospital with an operating theatre. The distribution is suspended while control of the crowd is regained.

Tools: kit contents, CPR card and equipment checks

The contents below are indicative. They must be validated by the organisation's medical adviser, adapted to the risks of the context and to the training level of staff, and compliant with national regulations. No medication should be added to a kit without a corresponding protocol and training.

Vehicle kit and office kit

Category	Contents	Remarks
Protection	Non-sterile gloves in several sizes, pocket mask with valve, safety glasses, alcohol-based hand rub, waste bags	Gloves are the consumable that runs out fastest
Bleeding	Commercial tourniquet (at least one per vehicle, more in high-risk areas), emergency pressure dressings, gauze, haemostatic dressing if trained	Train staff to apply it on themselves and on a colleague
Wounds and burns	Sterile gauze, bandages, adhesive tape, cling film or burn dressing, plenty of clean water	Cling film covers a burn after cooling
Immobilisation	Triangular bandages, malleable splints, blunt-ended scissors	Often forgotten in vehicle kits
Environment	Insulating blankets, oral rehydration salts	A blanket is useful even in hot weather for a bleeding casualty
Documentation	Assessment and monitoring forms, marker, pencil, alert card and emergency numbers	Check the numbers every month
Office equipment	Defibrillator with spare adult and paediatric pads, stretcher or soft carry sheet	Check the device's status indicator and the expiry dates of pads and battery

Monthly check sheet

Checkpoint	Compliant	Action
Kit seal intact or full inventory completed		
Expiry dates (sterile dressings, rehydration salts, pads)		
Tourniquet present, packed, accessible without unpacking everything		
Defibrillator status indicator showing ready		
Emergency numbers tested		
Checker's signature and date		

CPR reminder card (to be laminated)

1. Is the scene safe?
2. Unresponsive? Shout for help.
3. Open the airway, check breathing (no more than 10 seconds).
4. No normal breathing: have someone call for help (on speaker) and fetch the defibrillator, naming the people you send.
5. Compressions: centre of the chest, 5 to 6 cm, 100 to 120 per minute, full recoil.
6. If trained: 30 compressions, 2 rescue breaths. Otherwise: continuous compression-only CPR.

7. Defibrillator: switch on, follow the prompts, nobody touches during analysis and shock, resume immediately.
8. Change rescuers every two minutes; record the times.

Resuscitation record form

Information	Time or value
Time of collapse or discovery	
Witnessed collapse (yes or no)	
Time compressions started	
Time the defibrillator arrived and was switched on	
Times and number of shocks delivered	
Rescue breaths given (yes or no)	
Time normal breathing resumed, if applicable	
Time responders arrived and name of the person who took over	

Common mistakes, contextual variations and what assessors expect

Common mistakes and how to avoid them

- **Hesitating to start** for fear of doing it wrong or causing harm. Ribs may fracture during effective CPR; this is no reason to stop. A casualty in cardiac arrest cannot be made worse by CPR: without it, he or she will die.
- **Compressions too shallow**, especially after the first minute. Regular changeovers and monitoring by the team leader are the remedy.
- **Stopping compressions to check** breathing or pulse regularly: only the defibrillator or obvious signs of life justify stopping.
- **Delaying the shock** to finish a cycle or to check: follow the device.
- **Defibrillator unusable**: flat battery, expired pads, device locked in an office. Monthly checks and a location accessible at all times.
- **Tourniquet too loose, badly placed, or loosened** by the first aider "to relieve the casualty"; tourniquet hidden under a blanket with no time recorded.
- **Releasing direct pressure** to see whether the bleeding has stopped: maintain pressure without releasing it.
- **Giving fluids by mouth** to a casualty in shock or who will need surgery.
- **Blind finger sweeps** of the mouth in choking.

Contextual variations

Sudden-onset crisis: large numbers of casualties, few defibrillators, priority given to bleeding control and airway management. Traumatic cardiac arrest in a mass casualty situation falls

under triage (day 4): resources are directed to the casualties who can be saved.

Protracted crisis: skills erode. The education guidelines stress frequent, short refreshers; a practical manikin session of a few tens of minutes several times a year maintains skills better than a long course that is rarely repeated.

Camps and distribution sites: plan for a visible first aid post, a dedicated first aider who does not take part in the distribution, and an evacuation route to the site clinic. Train community volunteers.

Urban settings: public-access defibrillators may exist; identify them and include them in the plan.

Insecurity: CPR on a casualty in an area exposed to gunfire is not feasible; the priority is to take cover, then control bleeding. First aid training for conflict zones, such as that of the ICRC, clearly distinguishes what can be done under threat from what can only be done in a safe area.

Partners with limited capacity: budget for training manikins, training tourniquets, kits and refresher courses. A commercial tourniquet costs little compared with a life; its absence from an exposed vehicle is hard to justify during a post-incident investigation.

What assessors look for

- Percentage of field staff certified and up to date, by base and by partner.
- Commercial tourniquets in exposed vehicles and defibrillators in offices and bases where justified.
- CPR exercises carried out and timed.
- Incident reports describing the actions taken, the time frames and the lessons learned.
- Consistency of training with current guidelines (IFRC 2020, ERC 2021 or national protocol).

Interview questions and key references

1. "How do you recognise cardiac arrest, and what do you do in the first minute?"

A good answer cites the two criteria (unresponsive, not breathing normally), the pitfall of agonal gasps, early alerting and sending a named person to fetch the defibrillator, followed by the immediate start of high-quality compressions. It mentions the option of compression-only CPR and the 30:2 sequence for trained people.

2. "Why install a defibrillator at a base, and how do you make sure it will be used?"

The candidate explains that early defibrillation is the single most decisive factor for survival in certain cardiac arrests, then talks about an accessible location known to everyone, staff training, regular checks of the device, pads and battery, and exercises.

3. "A colleague is bleeding heavily from the leg after an accident. Describe what you do."

The candidate begins with safety and gloves if possible, then firm direct pressure, a tourniquet if pressure is insufficient or not possible, the time recorded, the tourniquet left visible and not

loosened, prevention of hypothermia, alerting and evacuation to a surgical facility. He or she mentions that elevation and pressure points have been abandoned.

4. "A child chokes during an activity in a child-friendly space. What must the team be able to do?"

The candidate distinguishes an effective cough from severe obstruction, describes alternating back blows and abdominal thrusts in a child over one year, and back blows and chest thrusts in an infant, what to do if the child loses consciousness, and the need for medical review after abdominal thrusts. He or she adds team training and the presence of a trained person at every activity.

5. "How do you maintain CPR skills in a team with high turnover?"

The candidate cites short, frequent refreshers, manikin practice, timed exercises, tracking of certifications, training built into the induction of new arrivals, and the distribution of reminder cards.

Key references

- *International First Aid, Resuscitation and Education Guidelines* (2020): IFRC.
- *European Resuscitation Council Guidelines* (2021): chapters on adult basic life support, paediatric life support, special circumstances and first aid.
- ILCOR annual scientific consensus statements on resuscitation and first aid.
- *First Aid in Armed Conflicts and Other Situations of Violence*: ICRC.
- *Basic Emergency Care: approach to the acutely ill and injured*: WHO and ICRC.
- *The Sphere Handbook* (2018), health standards on trauma care and emergencies.

> Reminder: this online course does not replace certified hands-on training. CPR, choking relief and tourniquet application require supervised practical training and regular refreshers.

Exercise: the vehicle kit

Check the first aid kit of one of your organisation's vehicles or offices. Does it contain gloves, pressure dressings, a tourniquet, a survival blanket, oral rehydration salt sachets, scissors, a pocket mask for rescue breaths and the list of emergency numbers? List what is missing and the expiry dates, and pass it on to the logistician.

Key takeaways

- Unresponsive and not breathing normally: alert, AED, chest compressions.
- Compressions 5 to 6 cm deep, 100 to 120 per minute; 30:2 if trained, otherwise compressions only.
- Breathing but unresponsive: recovery position and monitoring.
- Severe choking: 5 back blows, 5 abdominal thrusts, alternately.
- Bleeding: direct pressure; tourniquet if not enough, time written down.

Quiz

1. The correct rate of chest compressions in adults is:
   A. One every 5 seconds
   B. 60 per minute
   C. 100 to 120 per minute
   D. 200 per minute

2. A person is choking but coughing hard and speaking. You:
   A. Encourage them to cough and stay close
   B. Give abdominal thrusts
   C. Give 5 back blows
   D. Give them a drink

3. After applying a tourniquet, you must:
   A. Hide it under clothing
   B. Write down the time and not loosen it
   C. Remove it as soon as the bleeding stops
   D. Loosen it every 10 minutes

Quiz answers : 1. B · 2. C · 3. B

Day 3 : Injuries, environment and psychological first aid

Objectives

- Manage burns, wounds, fractures and head injuries.
- Recognise and treat heatstroke, hypothermia, dehydration and bites.
- Provide psychological first aid.

Burns, wounds and fractures

Burn: cool immediately with clean, cool water for **at least 20 minutes**; remove rings and clothing that is not stuck; cover with cling film or a clean non-stick dressing. Never butter, oil, toothpaste or ice; do not burst blisters. Large burns, burns to the face, hands or genitals, or burns in a child: medical advice.

Simple wound: wash with clean water and soap, cover with a clean dressing; check tetanus vaccination. **Embedded object**: do not remove it; hold it in place with dressings around it.

Fracture or sprain: do not try to put the bone back in place; immobilise in the position found (improvised splint, sling) and check the colour and feeling of the fingers or toes. Open fracture: cover the wound with a clean dressing.

Head and spine: after a fall or road accident, limit head and neck movement in a conscious casualty. Loss of consciousness, repeated vomiting, confusion or drowsiness after a blow to the head: medical evacuation.

Heat, cold and dehydration

Heatstroke (very high temperature, confusion, hot skin, sometimes seizures) is life-threatening. Cool immediately, preferably by immersion in cold water up to the neck if possible; otherwise, soak the person and fan them, in the shade. **Heat exhaustion** (fatigue, cramps, sweating): rest in the shade and a rehydration solution.

Hypothermia: get the person to shelter, remove wet clothing, insulate from the ground, cover (survival blanket), rewarm gradually and handle gently.

Diarrhoea and dehydration: give **oral rehydration salts** (ORS) in small, frequent sips; continue breastfeeding infants. Danger signs requiring medical care: a child who is lethargic or unable to drink, sunken eyes, blood in the stool, profuse watery diarrhoea (think of cholera).

Bites, stings, seizures and sudden illness

- **Snakebite**: calm the casualty and lay them down, immobilise the limb, remove rings and bracelets, and transport them to a facility with antivenom. No tourniquet, no cutting, no suction, no ice.

- **Animal bite** (dog, monkey, bat): wash the wound for 15 minutes with soap and water, then seek care quickly for rabies prevention.
- **Seizures**: protect from surrounding objects, put nothing in the mouth, do not restrain movements; note the duration; afterwards, recovery position. Call for help if the seizure lasts more than 5 minutes or recurs.
- **Low blood sugar** in a person with diabetes who is conscious and able to swallow: sugar, juice or a sweet drink.
- **Severe allergic reaction** (swelling of the face, difficulty breathing): help the person use their adrenaline auto-injector if they have one, and call for help.

Psychological first aid

After a violent event, most people have normal reactions (fear, tears, shock, anger). **Psychological first aid** (WHO, 2011) offers humane, practical support without forcing anyone to talk.

- **Look**: safety, urgent needs, people in serious distress.
- **Listen**: introduce yourself, offer help, listen without judging, help the person calm down.
- **Link**: to basic needs (water, shelter, news of loved ones), information and services (health, mental health, protection).

Avoid promising what you cannot deliver, forcing someone to talk or giving your own interpretation. Look after yourself too: after a difficult intervention, talk to a colleague or to your organisation's psychological support.

Trauma in detail: burns, wounds, head, spine and limbs

> This online course does not replace certified hands-on first aid training. Immobilisation, dressing and casualty-handling techniques require practical learning, supervised by a qualified instructor, and regular refreshers.

Thermal burns: the complete method

1. **Stop the burning process**: move the person away from the source; if clothing is on fire, roll the person on the ground or smother the flames with a blanket.
2. **Cool** immediately with clean, cool water, preferably running, for **at least 20 minutes**, as recommended by the IFRC and ERC guidelines. Cooling remains useful even if it starts a little late. No ice or iced water.
3. **Remove** rings, watches, bracelets and clothing that is not stuck to the skin during cooling, before swelling develops.
4. **Protect against hypothermia**: in children and when the burn is extensive, cool the burned area while keeping the rest of the body warm. This is an important point of vigilance in displacement sites, where water may be cold and shelters poorly insulated.
5. **Cover** loosely with cling film laid in strips, or a clean non-adherent dressing. Do not burst blisters, and do not apply anything else (no paste, oil, butter, toothpaste or traditional

remedy).

6. **Assess severity** in order to decide on referral.

To estimate the extent, a simple rule is that the palm of the casualty's hand, including the fingers, represents about 1% of his or her body surface area. Burns must be seen by a professional when they are extensive or deep (white, leathery or blackened skin, with little pain), when they affect the face, hands, feet, joints, perineum or genitals, when they go all the way round a limb, when they involve a young child or an older person, or when there is a risk of airway involvement (burn in an enclosed space, soot around the mouth or nose, hoarse voice, cough).

Chemical and electrical burns

- **Chemicals**: protect yourself (gloves, goggles), remove contaminated clothing, brush off any dry powder before rinsing, then rinse with plenty of water for a long time. Identify the product (label, safety data sheet) and pass on the information.
- **Chemical in the eye**: immediate, copious and prolonged irrigation with clean water, eyelids held open, directing the water so as not to contaminate the other eye; urgent medical referral.
- **Electricity**: cut off the power before any contact. The visible burn may be small while internal injuries and the risk of cardiac arrhythmia are significant: every casualty of an electrical injury must be medically assessed. Be ready to perform CPR.

Wounds: clean, cover, refer

The guidelines recommend cleaning superficial wounds with plenty of clean water, running if possible. Then cover with a clean dressing. Referral to a health worker is required for a deep or large wound, a wound contaminated with soil, a bite wound, a wound to the hand or face, or a wound in a person whose tetanus vaccination is not up to date or is unknown. An embedded object is not removed: it is stabilised with dressings placed around it.

Head injury

After a blow to the head, the first aider looks for **red flags** requiring urgent medical assessment: loss of consciousness, even brief; confusion; increasing drowsiness; repeated vomiting; worsening headache; seizures; weakness or numbness in a limb; speech or vision disturbance; blood or clear fluid leaking from the nose or ears; unusual behaviour. The European guidelines advise against a first aider using a simplified scale alone to decide that a concussion is minor: if in doubt, professional advice is needed. The casualty should not be left alone or drive in the hours that follow.

Suspected spinal injury

Current guidelines **do not recommend** the application of a cervical collar by a first aider, because of possible adverse effects and the absence of proven benefit. A conscious casualty is asked not to move and head and neck movement is limited; if necessary, the head is held manually in the position in which it was found. In an unresponsive casualty who is breathing, protecting the airway takes priority: if the casualty must be turned onto his or her side, this is done while keeping movement of the head-neck-trunk axis to a minimum, with several people if possible.

Limbs: fractures, sprains, dislocations

- Do not try to realign a deformed limb; immobilise it in the position found or the least painful position, including the joints above and below.
- Check the colour, warmth and sensation of the extremities before and after immobilisation.
- Open fracture: cover the wound with a clean dressing, control any bleeding, do not push the bone back in.
- Sprains and closed bruising: cold (ice wrapped in a cloth or a cold pack) can relieve pain, for limited periods and without direct contact with the skin.
- Severe pain in the thigh or pelvis after violent trauma: risk of internal bleeding; monitor for signs of shock and arrange evacuation.

Environmental and medical emergencies: heat, cold, dehydration, bites, poisoning

Heat-related illness

Form	Signs	What to do
Heat cramps	Muscle pain during or after exertion in the heat	Rest in the shade, gentle stretching, a drink containing electrolytes (rehydration solution)
Heat exhaustion	Fatigue, weakness, heavy sweating, nausea, headache, dizziness, normal consciousness	Rest in the shade or somewhere cool, lie down, cool (wet the skin, fan), give a rehydration solution or a drink containing electrolytes; if no rapid improvement, seek medical advice
Heat stroke	Behavioural changes, confusion, seizures, loss of consciousness; hot skin, dry or sweating; very high temperature	Life-threatening emergency. Immediate active cooling, preferably by immersing the body up to the neck in cold water; failing that, any available cooling method (dousing with water, fanning, wet cloths). Raise the alarm. Give nothing to drink if consciousness is impaired.

The ERC and IFRC guidelines stress early cooling: it must start on site, before transport, and must not wait for a temperature reading. The decision to stop it rests with the protocol and, if possible, medical advice.

For prevention, organisations can use the wet bulb globe temperature (WBGT) index to adjust physical work, schedule distributions at cooler times of day, provide shade, water and breaks, and pay particular attention to older people, young children, pregnant women, people who are ill and workers wearing heavy equipment.

Cold

Hypothermia: shivering, cold skin, clumsiness, then confusion, drowsiness and cessation of shivering in severe forms. Shelter the person from wind and moisture, remove wet clothing, insulate from the ground, cover including the head, handle gently (sudden movements can trigger a cardiac arrhythmia), and give a warm sweet drink only if the person is conscious and

swallowing normally. **Frostbite**: do not rub, and do not rewarm if refreezing is possible before reaching a safe place; protect and refer.

Diarrhoea and dehydration

The reduced-osmolarity oral rehydration salts (ORS) recommended by WHO and UNICEF must be prepared strictly according to the instructions on the sachet, with safe drinking water or treated water, and the solution keeps for a limited time only. An over-concentrated solution is dangerous, especially for infants. In children, IMCI recommends continuing breastfeeding and feeding; zinc treatment is the responsibility of a health worker.

Signs of severe dehydration according to IMCI, which require management in a health facility: lethargy or unconsciousness, inability to drink or drinking poorly, sunken eyes, skin pinch that goes back very slowly. Profuse watery diarrhoea of sudden onset, especially in adults and in an epidemic context, should raise suspicion of cholera and trigger an alert to the disease surveillance system.

Bites and stings

- **Snakebite**: in line with the WHO guidelines for the management of snakebites, reassure, lay the person down and immobilise the limb and if possible the whole body, remove rings and tight clothing, and transport without delay to a facility that has antivenom and can monitor the patient. No tourniquet, no incision, no suction, no ice, nothing applied to the wound, no traditional remedy. Some regional protocols provide for a pressure immobilisation bandage for certain species: it is applied only if the local protocol provides for it and the first aider has been trained in it. Note the time of the bite and the progression of signs (swelling, bleeding, drooping eyelids, difficulty swallowing or breathing).
- **Animal that may transmit rabies** (dog, cat, monkey, bat): WHO recommends immediate and thorough washing of the wound with soap and water for about fifteen minutes, followed by prompt consultation for rabies post-exposure prophylaxis, which is a medical emergency. Check tetanus vaccination status.
- **Scorpion**: reassure, immobilise, apply cold to the sting site, refer quickly, particularly young children, who are more at risk of severe forms.
- **Severe allergic reaction (anaphylaxis)**: breathing difficulty, swelling of the face or throat, feeling faint, rash. Help the person use their adrenaline auto-injector (outer thigh), raise the alarm; the European guidelines provide for a second dose after 5 minutes if signs persist and a second injector is available. Sitting position if breathing difficulty predominates, lying down if the person feels faint.

Other medical emergencies

- **Hypoglycaemia** in a person with diabetes who is conscious and able to swallow: the European guidelines recommend 15 to 20 grams of glucose (tablets), or failing that another fast-acting sugar (sweet drink, sugar), then reassessment after about fifteen minutes; if the person does not improve or loses consciousness, raise the alarm and give nothing by mouth.
- **Seizures**: protect the person, put nothing in the mouth, do not restrain movements, time the seizure; raise the alarm if the seizure lasts more than 5 minutes, recurs, or occurs in a

pregnant woman, an injured person or a person with no known history; afterwards, recovery position and monitoring.

- **Poisoning** (pesticide, household product, medication, fuel): protect yourself, move the person away from the source, remove contaminated clothing, do not induce vomiting, identify the product and quantity, contact the poison centre if there is one or the health facility. Organophosphate pesticide poisoning is common in rural areas: contamination of first aiders through the skin or vomit is a real risk.

Psychological first aid in practice: method, communication and limits

Psychological first aid (PFA), as described in the guide by WHO, War Trauma Foundation and World Vision International (2011) and taken up by the IFRC Reference Centre for Psychosocial Support, is neither therapy nor debriefing. It is a humane, supportive and practical response to a person who is suffering and may need help, respecting his or her dignity, culture and abilities. It sits at the first level of the intervention pyramid in the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007).

The step-by-step method

1. **Prepare**: learn about the event, the services available (health, protection, family tracing, distributions), safety and security issues, and cultural norms (who may speak to whom, how to approach a woman, an elder, a child).
2. **Look**: the safety of the area; urgent basic needs; people in acute distress (extreme agitation, complete shock, inability to care for themselves or their children, suicidal talk); people at particular risk (unaccompanied children, isolated older people, people with disabilities, survivors of violence).
3. **Listen**: introduce yourself (name, organisation), ask whether you can help, find a quiet and safe place, ask what the person needs and what worries them, listen without pressing them to talk, help them calm down (slow breathing, concrete reference points about place and time, presence).
4. **Link**: with basic needs and services, with reliable information (what is known, what is not known, when more will be known), with loved ones and social support. Physically accompany the person to a service when needed, rather than just pointing the way.
5. **Close**: say what will happen next, make sure the person is not left alone if vulnerable, and do not promise to come back unless it is certain.

What to say and what not to say

Do	Avoid
Be honest and trustworthy	Making promises you cannot keep
Respect the person's right to make their own decisions	Deciding for them, putting pressure on them
Speak calmly, in simple sentences, in their language if possible	Using technical jargon, speaking too fast
Acknowledge their losses and distress ("what you are going through is very hard")	Minimising ("it's nothing", "it could be worse"), offering religious or personal explanations
Allow silences, listen	Pressing them to tell their story, asking detailed questions about the event
Maintain confidentiality	Telling the person's story to others, photographing them
Refer to a professional when needed	Acting as a therapist, making a diagnosis

What PFA is not: psychological debriefing

The WHO guidelines for the management of conditions specifically related to stress (mhGAP programme) advise against single-session **psychological debriefing**, which consists of having people recount the event and the associated emotions in detail shortly afterwards, because it has shown no benefit and may be harmful for some people. This is one of the reasons why PFA never asks people to recount the event.

Children

Children's reactions depend on their age: regression (bedwetting, clinging to parents), sleep problems, repetitive play about the event, irritability. The priorities are to keep them with their parents or usual caregivers, to report an unaccompanied or separated child immediately to child protection actors, to speak to the child at his or her level in simple words, and to support the parents, who are the child's primary protective factor. Never photograph a child or record a child's identity outside the established child protection procedures.

When to refer immediately

Referral to a specialised service, urgently if necessary, is required when the person is injured or ill, is so distressed that he or she cannot care for themselves or their children, expresses thoughts of harming themselves or others, or is a survivor of sexual violence (referral to clinical management and psychosocial support services within the medical time frames, according to the person's choice and the established referral pathway).

Worked example: a distribution day in extreme heat

Fictitious context: Bassa-Nord displacement site, 9,400 people, hot season. The NGO "Terres Communes" is organising a distribution of shelter kits and non-food items for 1,150 households over two days. The forecast temperature exceeds 40 °C in the afternoon. The site health post, run by a partner, is open from 8:00 to 16:00, with a nurse and two nursing assistants; the

district hospital is 50 minutes away. The distribution team has 14 people, including 3 certified first aiders; a first aid post is set up in a tent, with a dedicated first aider who does not take part in the distribution.

Preparation: decisions taken the day before

- Distribution from 6:30 to 11:30, resuming at 15:30, based on the heat index and the advice of the health partner.
- Queues under stretched tarpaulins; water points every 50 metres; priority queue for older people, pregnant women, people with disabilities and people who are ill.
- First aid post equipped with: plenty of water, ORS, basins and buckets for cooling, blankets, a complete kit, assessment forms, a radio.
- Referral pathway agreed with the health post nurse, and a vehicle designated for transfer to the hospital.

Log of cases managed during the day

Time	Person	Problem	Care given	Referral
8:10	Woman, about 70 years old	Dizziness, sweating, nausea, normal consciousness	Rest lying down in the shade, wet cloths, ORS in small sips	Improved within 30 minutes; her entitlement handed over via the priority queue, accompanied home by a neighbour
9:25	Man, kit porter, about 30 years old	Calf cramps	Rest, gentle stretching, drink with electrolytes	Returned to a light task after one hour; rotation of porters introduced
10:40	Woman, about 25 years old, pregnant	Felt faint in the queue, no loss of consciousness	Placed on her left side in the shade, water, monitoring	Referred to the health post for examination, accompanied
11:05	Man, about 45 years old, distribution volunteer	Incoherent speech, staggering, burning-hot skin, then a brief seizure	Radio alert; immediately placed in an improvised tub (tarpaulin raised at the edges and filled with water), head supported above the water by a first aider, continuous dousing, fanning; recovery position after the seizure	Nurse on site within 6 minutes; cooling continued; transfer to hospital after consciousness improved, with cooling during the journey
11:20	Boy, about 8 years old, with his mother	Burn to the forearm from an overturned cooking pot near the cooking area	Cooling with clean water for 20 minutes while keeping the child covered, bracelet removed, cling film laid in strips	Burn of about two palms, with blisters: referred to the health post, mother present and informed
11:30	Man, about 35 years old	Dog bite to the calf	Washing with soap and water for about 15 minutes, clean dressing	Referred to the health post for assessment for rabies post-exposure prophylaxis and tetanus; information passed to the site health focal point

Analysis of the most serious case

The volunteer who suffered heat stroke had refused a break at 10:00 in order to finish a row. What protected him: rapid recognition of the behavioural changes as a sign of severity (rather than fatigue or alcohol consumption), immediate cooling on site without waiting for transport, and the equipment prepared in advance (water, tarpaulin, basins). What was missing: a mandatory break rule for staff and volunteers, and monitoring of their water intake.

Decisions for the second day

- Mandatory 15-minute breaks in the shade every hour for porters and volunteers; buddy pairs responsible for watching each other.
- Distribution stopped from 10:30 and resumed at 16:00.
- The staff cooking area moved away from the queues.
- A short briefing for volunteers on the signs of heat stroke.
- Incident report for the volunteer, submitted in line with procedure; follow-up of his condition by the volunteer manager.

The psychological dimension

The mother of the burned child was very agitated and blamed herself for the accident. The first aider introduced herself, had her sit next to her son during cooling, explained each step, acknowledged her fear without judging her, and accompanied her to the health post, telling her where she could collect her kit later. This is a direct application of PFA: look, listen, link, with no debriefing or questioning.

Tools, common mistakes and contextual variations

Tool 1: burns decision tree

Question	If yes
Burn from a flame, liquid or hot object?	Cool for at least 20 minutes, remove jewellery, cover with cling film
Chemical?	Protect yourself, brush off powder, rinse with plenty of water for a long time, identify the product
Electrical?	Cut off the power, systematic medical assessment, be ready to perform CPR
Face, hands, feet, perineum, joints, circumferential burn?	Medical referral
Larger than one or two palms, deep burn, child or older person?	Medical referral
Respiratory signs (soot, hoarse voice, cough, enclosed space)?	Emergency: raise the alarm, monitor breathing

Tool 2: heat-illness prevention checklist for an activity

- Weather forecast checked and timings adjusted.
- Shade for queues and teams.
- Safe drinking water accessible to all, ORS at the first aid post.
- Priority queue for vulnerable people.
- Mandatory breaks and rotation for physical work.
- Cooling equipment ready (plenty of water, container, tarpaulin).
- Dedicated first aider and known referral pathway.

Tool 3: PFA pocket card

- **Look**: safety, urgent needs, severe distress, people at risk.
- **Listen**: introduce myself, offer help, ask about needs, listen without pressing, help the person calm down.
- **Link**: basic needs, reliable information, loved ones, services; accompany if necessary.
- **Refer urgently**: injury, inability to care for oneself, thoughts of self-harm, sexual violence, unaccompanied child.
- **Look after myself**: take a break, talk with a colleague, use the organisation's support.

Common mistakes

- Cooling a burn for only a few seconds, or with ice; applying traditional remedies or toothpaste.
- Cooling a child's burn without keeping the child warm, risking hypothermia.
- Mistaking heat stroke for fatigue or drunkenness and delaying cooling until the hospital.
- Preparing ORS with a different amount of water from that stated on the sachet.
- Applying a tourniquet or making an incision after a snakebite; wasting time trying to catch or kill the snake.
- Neglecting a dog bite because the wound is small.
- Applying an improvised cervical collar or leaving a head-injured casualty alone.
- Asking a person in shock to tell their story "to get it off their chest".

Contextual variations

Sudden-onset crisis: an influx of minor and moderate injuries (wounds, fractures, burns), scarce clean water, overwhelmed facilities. Community first aiders manage simple injuries and refer serious cases. PFA is a priority in the first days.

Protracted crisis: environment-related illness (diarrhoea, heat, cold in shelters) and household burns in overcrowded shelters predominate. Prevention (layout of cooking areas, shelter insulation, access to water) is the responsibility of the shelter, WASH and health sectors, and first aiders can report the risks they observe.

Camps: high density, open fires, fire risk; a fire evacuation plan and first aid for burns should be prepared with the site manager.

Urban settings: carbon monoxide poisoning (heating or a generator in an enclosed space), electrical injuries, falls. Ventilate and remove casualties from an enclosed space only without exposing yourself.

Remote management and partners: PFA can be delivered by trained non-specialists and is a priority skill for local partner teams and volunteers, provided that referral pathways to specialised services exist.

Insecurity: people may be exposed to repeated violence; do not create expectations of a return visit if access is not guaranteed; strictly protect the information collected.

What assessors look for

- Integration of environmental health risks into activity planning (heat, cold, water).
- PFA training for staff in contact with affected populations and the existence of a functioning referral pathway.
- Log of cases managed at activity sites and follow-up of referrals.
- Attention to the well-being of staff and volunteers (breaks, water, post-incident support).

Interview questions and key references

1. "How do you organise a distribution in extreme heat to reduce health risks?"

A strong answer covers timings, shade, water, priority queues, mandatory breaks for staff and volunteers, a first aid post with a dedicated first aider and cooling equipment, a referral pathway agreed with the health partner, and the ability to suspend the activity.

2. "What is the difference between heat exhaustion and heat stroke, and why does it matter?"

The candidate cites altered consciousness or behaviour as the sign of heat stroke, explains that it is a life-threatening emergency requiring immediate active cooling on site, preferably by cold-water immersion, and that heat exhaustion is treated with rest, cooling and rehydration.

3. "A colleague is bitten by a snake in the field, three hours from the hospital. What do you do?"

The candidate describes rest, immobilisation, removal of jewellery, the prohibition of tourniquets, incisions, suction and ice, raising the alarm, choosing a facility with antivenom, monitoring for signs of severity, and mentions advance preparation (mapping the facilities with antivenom in the medical plan).

4. "What is psychological first aid, and how does it differ from debriefing?"

The candidate presents the look, listen, link principles, the absence of pressure to talk, the practical and humane nature of the support, and explains that WHO advises against single-session psychological debriefing. He or she cites the situations that require specialised referral.

5. "How would you train community volunteers in first aid in a camp?"

The candidate mentions a partnership with the Red Cross or Red Crescent National Society, content adapted to the common risks in the camp (burns, diarrhoea, heat, wounds), certified hands-on training, equipment, a referral pathway to health facilities, refresher training and supervision.

Key references

- *International First Aid, Resuscitation and Education Guidelines* (2020): IFRC.
- *European Resuscitation Council Guidelines* (2021), "First Aid" chapter: European Resuscitation Council.
- *Psychological First Aid: Guide for Field Workers* (2011): WHO, War Trauma Foundation and World Vision International.
- *A Guide to Psychological First Aid*: IFRC Reference Centre for Psychosocial Support.

- *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2007): Inter-Agency Standing Committee.
- WHO Guidelines for the Management of Conditions Specifically Related to Stress (mhGAP programme, 2013).
- WHO Guidelines for the Management of Snakebites, and WHO position paper on rabies vaccines.
- Integrated Management of Childhood Illness (IMCI) strategy: WHO and UNICEF.
- *The Sphere Handbook* (2018), Health and Water Supply, Sanitation and Hygiene Promotion chapters.

> Reminder: this online course does not replace certified hands-on first aid training or specific training in psychological first aid. Both are learned through practice, with an instructor.

Exercise: three situations to decide

For each of these situations, write down the first three actions and the person to inform: (1) a child has spilled boiling water on their arm in a displacement site; (2) a driver is confused and burning hot after fixing a flat tyre in full sun; (3) a woman is bitten by a snake at the edge of a field, two hours from the hospital.

Key takeaways

- Burn: cool water for at least 20 minutes, then a clean dressing; nothing else.
- Fracture: immobilise without realigning; head injury with warning signs: evacuate.
- Heatstroke: cool immediately; diarrhoea: ORS and danger signs.
- Snake: immobilise and evacuate; no tourniquet, no cutting.
- Psychological first aid: look, listen, link, without forcing anyone to talk.

Quiz

1. A burn is cooled with cool water for:
   A. 30 seconds
   B. Burns should not be cooled
   C. Until blisters appear
   D. At least 20 minutes

2. For a snakebite, you should:
   A. Apply ice
   B. Cut and suck out the venom
   C. Immobilise the limb, calm the casualty and evacuate them to a facility with antivenom
   D. Apply a tight tourniquet

3. The three actions of psychological first aid are:
   A. Question, diagnose, treat
   B. Tell, relive, forget
   C. Look, listen, link
   D. Isolate, calm, send away

Quiz answers : 1. B · 2. C · 3. A

Day 4 : Mass casualties, triage and war wounds

Objectives

- Organise the response to a mass casualty incident.
- Apply START triage and prioritise actions.
- Manage war wounds and look after the team after the event.

Mass casualty incident: organise before treating

When the number of injured exceeds the resources on hand, the objective changes: it becomes **doing the greatest good for the greatest number**. The team leader does not treat: they **organise**. They check safety (second explosion, shooting, collapse), call for help, designate a safe gathering area, deploy the first aiders and keep a register of casualties.

Organisations working in conflict zones prepare a **mass casualty plan** with local health facilities: roles, extra kits (tourniquets, pressure dressings, blankets), means of transport, contacts for the Red Crescent or Red Cross and the ICRC.

START triage

START triage classifies each casualty in less than a minute:

- **Green**: the casualty can walk. They are gathered in a safe area and will be reassessed.
- **Black**: not breathing, even after the airway is opened.
- **Red** (immediate): breathing more than 30 times a minute, or no radial pulse (or capillary refill over 2 seconds), or unable to follow simple commands.
- **Yellow**: all other casualties who cannot walk.

During triage, only two actions are performed: **stopping catastrophic bleeding** (tourniquet) and **placing an unconscious casualty who is breathing in the recovery position**. Triage is repeated, as casualties' condition changes.

War wounds while awaiting evacuation

In war trauma, **catastrophic bleeding** is treated first, even before the airway: tourniquet on limbs, firm pressure and packing the wound with gauze for junctional wounds (groin, armpit, neck). Then come the airway, breathing, circulation and the prevention of **hypothermia** (survival blanket, even in hot weather, because a bleeding casualty cools quickly).

A **chest wound** that is bubbling is left open or covered with a non-occlusive dressing. An abdominal wound with protruding organs is covered with a clean damp cloth, without pushing anything back in. An embedded object is never removed. Nothing is given to drink to an injured person who will need surgery.

After the event: the team and the witnesses

Responders are exposed to traumatic scenes. In the following days, offer a **voluntary discussion** focused on practical needs, without forcing anyone to talk. Lighten the workload, watch for signs that persist beyond a few weeks (sleep problems, avoidance, irritability) and refer to professional psychological support.

Also hold an operational **lessons-learned review**: what worked, the missing equipment, the contacts to update. Restock the kits used immediately.

Preparing a mass casualty plan: organisation, zones and roles

> This online course does not replace certified hands-on first aid training, nor the specialised training in first aid in conflict or mass casualty situations offered by the ICRC, Red Cross and Red Crescent National Societies or health authorities. Triage and trauma care are learned through practice and simulation exercises.

A mass casualty incident is defined less by a number than by a ratio: there is a mass casualty situation when the number and severity of casualties exceed the immediate capacity of the people and resources on site. For a team of four first aiders in a market, five seriously injured people are enough. The WHO guidance on mass casualty management systems points out that the response is above all a matter of prior organisation: what has not been prepared and exercised will not work on the day.

The principles that change compared with a single casualty

- **The greatest good for the greatest number**: resources go first to the casualties who can be saved by simple, rapid interventions.
- **Organise before treating**: the first trained person to arrive takes on coordination, assesses and organises, rather than stopping at the first casualty.
- **Limited interventions during triage**: control of catastrophic bleeding and opening or protecting the airway, then move on to the next casualty.
- **Repeated triage**: casualties' conditions change; each casualty is reassessed regularly and at every stage (treatment area, evacuation, arrival at hospital).
- **Non-discrimination**: priority is set by medical urgency alone, in accordance with international humanitarian law, which protects the wounded and sick without adverse distinction.

The zones

Zone	Function	Points of attention
Danger zone	Site of the incident	Access only after a security assessment (secondary explosion, gunfire, collapse, fire, unexploded ordnance); personnel kept to a minimum
Casualty collection point	Casualties brought out of the danger zone, triage	At a safe distance, under cover, accessible to vehicles
Treatment area	Casualties grouped by category (red, yellow, green)	One person in charge per category; the green area kept apart so that it does not overrun the others
Evacuation point	Loading for transport to health facilities	Log of every departure: who, to where, in which vehicle, at what time
Area for the deceased	Bodies of those who have died	Set apart, with dignity, without unnecessary handling; competent authorities informed

The roles

- **Coordinator**: does not treat. Assesses security with the security focal point, alerts the base and health facilities, designates zones and roles, tracks the number of casualties per category, requests reinforcements and transport, and decides to halt operations if security deteriorates.
- **Triage officer**: moves through the casualties, applies the triage method, performs only the interventions authorised during triage, and marks each casualty (wristband, tag or colour marking).
- **Zone first aiders**: care for the casualties in their category, monitor, reassess and report any deterioration.
- **Transport officer**: organises evacuations according to priorities and facility capacity, keeps the log.
- **Communications and logistics**: radio liaison, restocking of kits, water, lighting, management of bystanders and families.

What the written plan must contain

1. Activation thresholds and internal alert chain.
2. Security rule: who decides that an intervention is possible, and on what criteria.
3. List of health facilities with their actual surgical capacity and their capacity to receive several casualties at once, and verified on-call contacts.
4. Coordination with the health cluster, the ICRC, the National Society and health authorities; knowledge of any emergency medical teams deployed, according to the classification of the WHO Emergency Medical Teams initiative.
5. Pre-positioned stocks: tourniquets, pressure and haemostatic dressings, insulating blankets, gloves, colour tags or tapes, soft stretchers, head torches, logbooks.
6. Transport that can be mobilised and agreements with other organisations.

7. Staff support procedure after the event.
8. Exercise schedule.

Triage in practice: START, re-triage and other methods

START triage (Simple Triage and Rapid Treatment), presented in the previous sections, is one of the most widely taught field triage methods. Others exist, such as SALT or simplified triage tools used by certain services. No method is perfect: studies show significant rates of over-triage and under-triage. What matters is that the whole team uses **the same method**, the one from its training and the local health system, and that it has practised it.

START: the detailed sequence

Step	Question	Result
1	Can the casualty walk?	Yes: green. The casualty is asked to go to the designated collection point.
2	Is the casualty breathing?	No: open the airway. If breathing does not resume: black. If it resumes: red, and a position that protects the airway.
3	Respiratory rate above 30 per minute?	Yes: red.
4	Radial pulse absent, or capillary refill longer than 2 seconds?	Yes: red. Control any catastrophic bleeding.
5	Does the casualty obey simple commands ("squeeze my hand")?	No: red. Yes: yellow.

Capillary refill is unreliable in the cold or in poor light: checking the radial pulse is then preferable. The triage officer spends very little time on each casualty and does not carry out a full assessment.

Triage of children

The START thresholds are designed for adults: in children, the normal respiratory rate is higher and respiratory arrest is more often reversible with a few rescue breaths. Paediatric adaptations exist (for example JumpSTART, which provides for rescue breaths in a child who is not breathing but has a pulse). They require specific training. Failing that, the principle is not to classify a child as black too quickly.

Re-triage

The first triage is rapid and approximate. It is followed by a second, more complete triage in the treatment area, and then by triage for evacuation, which takes into account the number of places in vehicles, facility capacity and transport time. A yellow casualty who becomes confused, whose breathing speeds up or who turns pale moves to red; a stabilised red casualty may wait so that a more serious casualty can leave first. The categories written on the tags are updated, with the time.

Triage at the hospital

Field triage is not surgical triage. In hospitals receiving weapon-wounded patients, the ICRC teaches triage based on the need for and urgency of surgery, which distinguishes in particular between patients requiring immediate surgery, those whose surgery can wait, those with minor injuries, and those whose injuries are so severe that they cannot be saved with the resources available. The first aider does not have to apply this triage, but the handover (interventions performed, tourniquet times, trend) facilitates this work.

Documentation

Each triaged casualty receives a visible marking (triage tag, colour tape or marker writing on the forehead or arm) showing the category, the time and the interventions performed, in particular the time a tourniquet was applied. The coordinator keeps a log with a number for each casualty, the category, the destination and the departure time. This log makes it possible to answer families, avoid duplicates and report to the authorities and the health cluster.

> Triage is morally gruelling: classifying a casualty as black means accepting not to stop beside that person. This choice, based on a shared method, makes it possible to save other lives. It must be prepared for in training and acknowledged in the support provided to staff after the event.

Weapon and blast injuries: detailed management until evacuation

Gunshot, fragment and blast injuries have specific characteristics: high energy, internal damage more extensive than the visible wound, contamination, and often multiple wounds in the same casualty. The ICRC manual *First Aid in Armed Conflicts and Other Situations of Violence* and the WHO and ICRC Basic Emergency Care approach structure management according to a sequence that begins with catastrophic bleeding.

Protect yourself first

Under fire or in an exposed area, the only reasonable action is often to take cover and, if this can be done without further exposure, to bring the casualty into cover. A tourniquet can be applied quickly to a heavily bleeding limb before moving. All other care waits for a safe area. Humanitarian organisations never ask their staff to expose themselves to gunfire in order to provide assistance; their security policy must state this explicitly.

The sequence in a safe area

Priority	Problem	First aider's actions
1	Catastrophic bleeding	Tourniquet on a limb; direct pressure; packing and pressure of junctional wounds (groin, armpit, base of the neck) with gauze or a haemostatic dressing if trained
2	Airway	Open it; turn an unresponsive casualty who is breathing onto the side; let a conscious casualty with facial trauma adopt the position that allows breathing (often sitting, leaning forward)
3	Breathing	Look for chest wounds, including on the back and under the armpits; leave a sucking chest wound open to the air or cover it with a non-occlusive dressing; monitor for worsening breathing difficulty
4	Circulation	Look for other bleeding, apply pressure; recognise the signs of shock; lay the casualty down
5	Hypothermia and other injuries	Insulate from the ground, cover, even in hot weather; cover wounds; immobilise fractures; look for exit wounds

Essential technical points

- **Open chest wound**: the IFRC and ERC guidelines recommend that first aiders do not apply an occlusive dressing, as it may lead to a build-up of air under pressure in the chest. The wound is left open to the air or covered with a non-occlusive dressing, and bleeding is controlled with local pressure if necessary. Any worsening of breathing is reported immediately.
- **Abdominal wound with protruding organs**: do not push anything back in; cover with a clean, moistened cloth; lay the casualty down, knees slightly bent if this gives relief; nothing by mouth.
- **Traumatic amputation**: tourniquet above the injury. The amputated part, if found without delaying care, is wrapped in a clean cloth, placed in a bag and kept cool without direct contact with ice. In a war setting, reimplantation is exceptional: time and energy go to the casualty.
- **Embedded object**: do not remove it; stabilise it.
- **Associated burns**: cool according to the usual rule, without causing hypothermia in a bleeding casualty.
- **Casualty trapped under rubble**: releasing a limb that has been compressed for a long time can lead to sudden deterioration. When possible, medical advice is sought before or during release, and the casualty is closely monitored afterwards. The safety of the structure comes first: no extrication without assessment.
- **Fluids by mouth**: nothing to drink for a seriously injured casualty who will probably need surgery, unless medically instructed in case of very prolonged evacuation.

Blast injuries

Four mechanisms are traditionally distinguished: the blast wave (injuries to air-containing organs: lungs, ears, intestines), projectiles and fragments, the casualty being thrown against obstacles, and other effects (burns, smoke inhalation, crushing, worsening of existing

illnesses). Two practical consequences for the first aider: a casualty who seems only slightly affected may later develop respiratory distress, and temporary deafness makes communication difficult. Anyone who was close to an explosion must be reassessed, even if walking.

Handover and evacuation

For each casualty, the first aider hands over: category and time of triage, mechanism, injuries identified, interventions performed and their times (especially tourniquets), and trend. Tourniquets remain visible. During transport, continuous monitoring and prevention of hypothermia continue. In conflict settings, respect for the emblem, the rules for passing through checkpoints and the team's neutrality often determine whether evacuation is possible at all.

Worked example: explosion at Doran market

Fictitious context: the town of Doran, in a low-intensity conflict zone. The NGO "Main Tendue" runs a protection and community health programme there. At 9:50, a device explodes in the market. The NGO team, six people including three certified first aiders (Ms N., team leader, Mr R., Mr S.) and a driver, is 300 metres away, with two vehicles and two trauma kits each containing four commercial tourniquets. Doran hospital has two operating theatres; the announced response time of the National Society's emergency teams is 25 minutes.

The first ten minutes

- **9:50 to 9:55**: Ms N. moves the team into cover behind a building and contacts the security focal point. Joint decision: wait a few minutes, observe, do not approach the crater, use an approach on the side opposite the explosion. The base is alerted and informs the hospital and the National Society.
- **9:56**: the security focal point authorises a limited intervention on the periphery, with immediate withdrawal at any alert. Ms N. takes on coordination and does not treat. Casualty collection point set up in the courtyard of a school 80 metres away, under cover and accessible to vehicles.
- **9:58**: Mr R. announces loudly in the local language: "If you can walk, come to the school." Eleven people go there: green category, looked after by two non-first-aider members of the team, who count them, settle them and observe them.
- **10:00 to 10:08**: Mr R. and Mr S. triage the casualties remaining on the ground.

The triage log

No.	Casualty	Findings	Intervention during triage	Category
1	Man, about 40 years old	Right leg torn off below the knee, catastrophic bleeding, responsive	Tourniquet at 10:01, time recorded	Red
2	Woman, about 30 years old	Not breathing, not breathing after airway opening	None	Black
3	Man, about 60 years old	Breathing 34 per minute, chest wound, obeys commands	Wound left unoccluded	Red
4	Adolescent	Cannot walk (probable leg fracture), breathing 22, radial pulse present, obeys commands	None	Yellow
5	Woman, about 50 years old	Unresponsive, breathing	Turned onto her side	Red
6	Man, about 25 years old	Heavily bleeding forearm wound, cannot walk (shock, stunned), radial pulse absent	Tourniquet at 10:04	Red
7	Woman, about 35 years old	Multiple fragment wounds to the legs, breathing 24, pulse present, obeys commands	None	Yellow
8	Man, about 70 years old	Breathing 20, pulse present, does not respond to simple commands (disoriented, deaf?)	None	Red (to be reassessed: deafness may distort the criterion)

Situation at 10:08: 19 casualties, of whom 5 red, 2 yellow, 11 green and 1 black. Five tourniquets remain available after two have been applied.

The coordinator's decisions

- **10:09**: radio message to the base: "19 casualties: 5 red, 2 yellow, 11 green, 1 dead. Two tourniquets applied at 10:01 and 10:04. Need 3 vehicles for stretcher transport. Hospital to be alerted: 5 seriously injured, including two amputations or limb wounds with tourniquets and one chest wound."
- **10:12**: re-triage. Casualty 8, reassessed using gestures, squeezes a hand on request: moved to yellow. Casualty 3 is breathing faster and becoming agitated: evacuation priority.
- **10:15**: first NGO vehicle leaves for the hospital with casualties 3 and 1, accompanied by Mr S.; evacuation log completed. The second vehicle remains available for the team in case of withdrawal.
- **10:22**: two National Society ambulances arrive. Handover by Ms N.: numbers per category, tourniquets and times, priority casualties (5 and 6), location of the deceased. The National Society first aiders take charge of care; the NGO team remains in support for the green area.

- **10:40**: a rumour of a second device spreads. The security focal point orders the team to withdraw. Ms N. checks that every member is present and informs the National Society first aiders before leaving.

The evacuation log

No.	Category at departure	Vehicle	Departure time	Destination	Escort
3	Red	NGO vehicle 1	10:15	Doran hospital	Mr S.
1	Red (tourniquet 10:01)	NGO vehicle 1	10:15	Doran hospital	Mr S.
5	Red	NS ambulance 1	10:26	Doran hospital	National Society
6	Red (tourniquet 10:04)	NS ambulance 1	10:26	Doran hospital	National Society
4, 7, 8	Yellow	NS ambulance 2	10:35	Doran hospital	National Society

What this example shows

- The security decision came before any intervention and framed it right up to the withdrawal.
- The coordinator treated no one: this is what made it possible to complete triage in under ten minutes, send a quantified alert and carry out re-triage.
- The "obeys commands" criterion can be distorted by blast-related deafness; re-triage corrected an over-triage.
- Tourniquet times were passed on twice (by radio and in the verbal handover), and were written on the tourniquets.
- The handover to the National Society was explicit, and the team knew when to withdraw.

After the event: staff support, lessons learned and tools

Staff support: a three-stage approach

Responders to a mass casualty incident are exposed to distressing scenes, difficult triage decisions and sometimes personal danger. The IASC Guidelines on Mental Health and Psychosocial Support, WHO recommendations and the Antares Foundation guidelines on managing stress in humanitarian workers converge on a stepped approach, with no compulsory psychological debriefing.

When	Actions	Responsible
The same day	Check that everyone is safe and unharmed; practical needs (rest, meals, contact with family); psychological first aid; clear information about what will happen next; immediate management of any blood exposure	Team leader, head of base
The following days	Voluntary group discussion focused on needs and mutual support, with no obligation to recount events; reduced workload; information on common reactions and on access to confidential psychological support	Head of base, human resources or staff well-being focal point
The following weeks	Discreet individual follow-up; referral to a professional if difficulties persist or worsen (sleep problems, flashbacks, avoidance, irritability, alcohol use, difficulties at work)	Human resources, psychological support provider

This support applies to all staff, including national staff, drivers, guards and volunteers, who are often more exposed and less often followed up. The CHS (Commitment 8) and duty of care require it.

The operational lessons-learned review

Separate from psychological support, the lessons-learned review (after-action review) focuses on organisation and equipment. It is held in the days that follow, with a facilitator who did not lead the intervention if possible.

1. What was supposed to happen according to the plan?
2. What actually happened (factual timeline, based on the logs)?
3. Why were there differences?
4. What to keep, what to change, who is responsible, and by when?

The conclusions feed into updating the plan, restocking (tourniquets, dressings, tags), training needs, and the incident report sent to headquarters and, depending on the agreements, to the donor.

Tool 1: triage and evacuation log

No.	Sex, estimated age	Category and time	Interventions and times	Re-triage	Evacuation (vehicle, time, destination)

Tool 2: mass casualty kit checklist

- Commercial tourniquets in numbers appropriate to the risk, and separate training tourniquets.
- Emergency pressure dressings, gauze, haemostatic dressings if staff are trained.
- Gloves in large quantities, eye protection.
- Insulating blankets.
- Triage tags or tapes in four colours, permanent markers.

- Soft stretchers, head torches, identification tabards for the coordinator and the triage officer.
- Triage and evacuation logs, START reminder card.

Common mistakes

- Intervening before the security assessment, and exposing the team to a secondary explosion.
- The coordinator starting to treat the first casualty and losing the overall picture.
- Staying a long time with one casualty during triage, or attempting prolonged CPR to the detriment of others.
- Failing to re-triage, or evacuating in order of arrival rather than by priority.
- Sending all casualties to the same facility without warning it, while another has capacity.
- Tourniquets with no time recorded, hidden under blankets.
- Letting the green area overrun the red area.
- Imposing a group debriefing in which everyone must recount the event.

Contextual variations

Sudden-onset crisis (earthquake, building collapse): trapped casualties, dust, aftershocks; coordination with search and rescue teams. **Protracted conflict**: repeated incidents, wear and tear on teams and stocks; regular exercises and staff rotation. **Camps**: fires, crowd crushes during distributions; joint plan with the site manager and health partners. **Urban settings**: many actors, risk of disorganisation; integrate into the authorities' system rather than create a parallel pathway. **Remote management**: national staff and partners carry the response; they must have the same training, equipment, insurance and support. **Partners with limited capacity**: budget for training, kits and exercises, and organise training with the National Society.

What assessors and donors look for

- An exercised mass casualty plan, coordinated with health facilities and other actors.
- Staff training in first aid in conflict settings and in triage.
- Checked pre-positioned stocks.
- Incident reports, lessons-learned reviews and follow-up of actions.
- Psychosocial support accessible to all categories of staff.

Interview questions and key references

1. "You hear an explosion close to your team. What do you do in the first five minutes?"

A strong answer begins with taking cover and accounting for the team, contacting the security focal point, alerting the base, assessing the risk of a secondary explosion, and then deciding whether or not to intervene in line with the organisation's policy. The candidate does not rush towards the casualties.

2. "Explain START triage and its limitations."

The candidate describes the sequence (walking, breathing, respiratory rate, radial pulse or capillary refill, obeying commands), the two permitted interventions, the need for re-triage, and the limitations: adult thresholds, criteria distorted by deafness, cold or poor light, over-triage and under-triage. He or she stresses the use of a common, practised method.

3. "How do you manage a casualty with a gunshot wound to the chest while awaiting evacuation?"

The candidate first controls any catastrophic bleeding elsewhere, looks for all wounds including on the back, leaves the chest wound open to the air or covers it with a non-occlusive dressing in line with current guidelines, places the casualty in the position that makes breathing easier, protects from the cold, monitors and hands over.

4. "How do you prepare a base for a mass casualty incident?"

The candidate cites the written plan (activation, security, zones, roles, facilities and capacities, transport, stocks, coordination with the health cluster, the ICRC and the National Society, staff support), training, exercises and lessons-learned reviews.

5. "How do you support your team after a traumatic event?"

The candidate describes the stepped approach: practical needs and psychological first aid on the same day, voluntary discussion with no obligation to recount events, reduced workload, follow-up, professional referral if difficulties persist, and attention to national staff, drivers and volunteers. He or she mentions that compulsory psychological debriefing is not recommended.

6. "An armed group demands that you treat its fighters first. How do you respond?"

The candidate recalls the principle of impartiality and the protection of the wounded and sick under international humanitarian law, without adverse distinction, priority set by medical urgency alone, the security of the team, and recourse to negotiation and to the support of coordination structures and, where appropriate, the ICRC.

Key references

- *International First Aid, Resuscitation and Education Guidelines* (2020): IFRC.
- *European Resuscitation Council Guidelines* (2021), "First Aid" chapter: European Resuscitation Council.
- *First Aid in Armed Conflicts and Other Situations of Violence*: ICRC.
- *War Surgery* (volumes 1 and 2): ICRC.
- *Mass Casualty Management Systems: strategies and guidelines for building health sector capacity* (2007): WHO.
- *Basic Emergency Care: approach to the acutely ill and injured*: WHO and ICRC.
- *Classification and Minimum Standards for Emergency Medical Teams*: WHO.
- *Health Care in Danger* initiative: International Red Cross and Red Crescent Movement.
- Geneva Conventions of 1949 and their Additional Protocols, provisions on the wounded and sick.
- *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2007); *Psychological First Aid: Guide for Field Workers* (WHO, 2011).

- *Managing Stress in Humanitarian Workers: guidelines for good practice*: Antares Foundation.
- *Core Humanitarian Standard on Quality and Accountability* (CHS), Commitment 8.

> Reminder: this online course does not replace certified hands-on first aid training, nor specialised training in triage and first aid in conflict settings. Only practical training and simulation exercises truly prepare you for a mass casualty incident.

Exercise: your mass casualty plan

For your base, write a one-page plan: who organises, gathering area, extra equipment to stock, health facilities and surgical capacity, means of transport, emergency contacts, and the procedure for supporting the team after the event.

Key takeaways

- Mass casualties: the leader organises and does not treat; safety first.
- START: green walks, black not breathing, red if breathing > 30, no radial pulse or not obeying commands, otherwise yellow.
- During triage: only tourniquet and recovery position.
- War: catastrophic bleeding first, then airway, breathing, circulation, hypothermia.
- Afterwards: voluntary discussion, psychological support, lessons learned, restocking.

Quiz

1. In a mass casualty incident, the team leader's role is mainly to:
   A. Treat the most seriously injured casualty
   B. Take photos
   C. Deal with the media
   D. Organise: safety, alert, triage, deployment of first aiders, register
2. During START triage, which actions are performed?
   A. Intravenous drips
   B. No actions
   C. Only stopping catastrophic bleeding and placing in the recovery position
   D. All the care each casualty needs

3. Why cover a bleeding casualty, even in hot weather?

A. To hide them

B. So that they sleep

C. Because they cool quickly and hypothermia worsens bleeding

D. It is not necessary

Quiz answers : 1. B · 2. B · 3. B