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# EMERGENCY AND HUMANITARIAN ACTION
# DEPARTMENT BRIEF
# September 2002

## WHO: TESTED BY DISASTERS

*WHO applies the public health approach and epidemiological methods to disaster reduction. WHO defines disasters as 'any occurrence that causes damage, ecological disruption, loss of human life, or deterioration of health services, on a scale sufficient to warrant an extra-ordinary response from outside the affected community'. Disasters and emergencies are public health affairs. WHO sees health and human survival as the cross-cutting objective and the measure of effectiveness of humanitarian assistance.*

Therefore, WHO sets for itself the goal " To reduce avoidable loss of life, burden of disease and disability in emergencies and post-crisis transitions". This is to be achieved by ensuring the presence and operational capacity in the field to strengthen coordinated public health management for optimal immediate impact, collective learning and health sector accountability.

Coordination is difficult, but essential; the number of health-related actors is constantly increasing, and there is great demand for accountability and quality standards. WHO is especially challenged to deliver under these circumstances. However, member countries, agencies and donors have the right to expect that the Organization, as UN technical agency, to be the leader in coordination of health response, as well as in building capacities for preparedness in the health sector.

Emergency and Humanitarian Action are central to WHO global functions. The permanent offices that the Organization has in most, if not all the countries and territories that are most vulnerable to disasters, give WHO a comparative advantage in this area of work (..." *we are there before, during and after a crisis*"..) but also great responsibilities. Emergencies or "exceptional situations" cannot be an excuse to accept the unacceptable: they just make it imperative that exceptional action is taken for public health. Even in the direst circumstances, there are key measures that can save lives, and WHO sees them as its core commitments.

WHO responsibilities provide clear terms of predictability and accountability, a precise list of what the Organization and the health partners must be ready to deliver in crises and, therefore, a blueprint for preparedness plans. Around these priorities, WHO promotes institutional capacities and linkages in member states and partner agencies. This process needs continuous strengthening, especially at country level, where each year one WHO office out of five faces a major crisis.

## THE DEPARTMENT OF EMERGENCY AND HUMANITARIAN ACTION:

Emergency and Humanitarian Action is a horizontal function of WHO internal co-ordination, service and support. As part of an international response system, the Department of EHA is the instrument that assists WHO to perform in emergencies and humanitarian action.

The *Office of the Director* ensures overall coordination, mobilizes and administers EHA's core resources:

- formulating global policies and strategies in consultation with regional offices, other WHO departments and international humanitarian partners
- ensuring regular and extra-budgetary funding for EHA core functions
- ensuring accountability and transparency vis-à-vis partners
- representing WHO in the Inter-Agency Standing Committee Working Group and other fora.

***Managing crises: mobilising partnerships in support of local health systems***

In Geneva, EHA staff are in daily contact with country and regional offices, trying to anticipate crises, reacting to alerts and striving to provide response to the needs in the field with technical assistance, supplies and financial resources.

A team for *Emergency Health Partnership* coordinates with the country and regional offices and a network of focal points in other WHO departments, operational partners, collaborating centers, and donor agencies. Activities include:

- Coordinating and conducting rapid health assessments.
- Mobilizing WHO's technical departments and external partners for the delivery of essential life-saving interventions
- Assisting in the mobilization of external resources for emergency in line with WHO's corporate priorities
- Providing technical and logistic back-stopping
- Facilitating coordination between national and international humanitarian actors, so as to ensure that field operations are in line with best public health practices.
- supporting special emergency programs, e.g. in occupied Palestinian territory and the Horn of Africa.

***Disseminating health intelligence and knowledge***

A team for *Health Intelligence and Capacity Building* produces, consolidates and disseminates information on health-related issues, as well as standards and best public health practices relevant to preparedness, response, rehabilitation and recovery. Activities include:

- Managing information and producing health intelligence
- Documenting lessons learnt, consolidating and communicating norms, best public health practices for disaster reduction
- Disseminating best public health practices
- Building competencies for disaster reduction within WHO
- Collaborating with specialized centers and academic institutions for training and research in emergency health management

**YOU CAN COUNT ON US:**

- ✓ To identify experts for rapid assessments and assist you with defining priorities. The *WHO handbook for Emergency Field Operations* will help you in this planning process.
- ✓ To assist writing project proposals, including those for the Consolidated Appeal Process.
- ✓ To facilitate dialogue with international donors and UN agency partners.
- ✓ To mobilize WHO's technical departments for life-saving interventions in your country.
- ✓ To help with the logistics of emergency operations and mobilize supplies through the UN Humanitarian Response Depot (UNHRD) in Brindisi.
- ✓ To facilitate coordination between national and international agencies and place humanitarian concerns in a perspective of national capacity building.
- ✓ To identify disaster related training programs implemented by WHO technical departments, partner agencies and academic institutions.
- ✓ *An Emergency Health Library Kit* can provide technical guidance to agencies operational in the field and assist you in coordinating the response. The Virtual *Health Library for Disasters* on a CD-ROM containing over 300 publications supplements the kit.
- ✓ Through the quarterly newsletter 'Health in Emergencies', you can inform a worldwide audience of your activities in emergencies. www.who.int/disasters/newsletter/.
- ✓ On the *EHA website*, www.who.int/disasters, you will find situational information including baseline statistics, health situation reports and epidemiological surveillance data. You can access all WHO disaster-related guidelines for effective programme planning.
- ✓ We can help access the expertise of *Collaborating Centers.*
- ✓ We can assist in your evaluations or lessons learnt workshops.

**HOW TO REACH US:** You can contact our department on any issue related to disasters. Contact details for the various projects can be found at www.who.int/disasters. Or send your e-mail to EHA@who.int, and we will forward it to the best person to answer your question.

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# ECOSOC 2002 Humanitarian Segment

## WHO technical contribution to the Panel

## *Reaching the vulnerable in the context of complex humanitarian emergencies and natural disasters*

**New York, 16 July 2002**

*I stress the need to protect health systems and ensure access to the basic necessities for life - even when there are hostilities*[1]

Just one year ago, in July 2001, the UN Secretary-General's call for Days of Tranquillity allowed safe passage for polio vaccinators in synchronized National Immunisation Days in the DR Congo and Angola.

In September 2001, even after the evacuation of international staff, the 1st round of the National Immunisation Days (NID) could take place in Afghanistan, thanks to the national staff of NGOs, UNICEF and WHO. A lull in the bombings allowed for a second round in November. During the campaign, Vitamin A was administered to children Under-5, thus improving their chances of survival through the winter.

**Health and Humanitarian Access**

"Humanitarian corridors" or "windows of tranquillity" are not new and they are deeply rooted in the history of medicine and public health. Already *before* Solferino, truces were called, e.g. for the care of the wounded on the battlefield. More recently, they have been established to allow safe passage for humanitarian medical supplies and/or immunisations. WHO was instrumental in the growth of the modern concept of humanitarian cease-fires. In the 1980's it was PAHO that conceived an initiative of cross-line negotiation on health priorities that allowed for an immunisation campaign in El Salvador that saw the collaboration of the Government, the rebel movement, ICRC, UNICEF, the Catholic Church, and others. In Afghanistan itself, cease fires for immunisations had already taken place in 1988/9, in 1994, 1996, 1997 and 2000.

Starting from 1986, WHO knows of at least 60 instances of Days of Tranquillity in 16 different countries[2]. Health can be a *bridge for peace*[3], and people's health needs peace, at least as much as it needs clean water, food and immunizations.

Any public health strategy is built on the principle of equitable, unhindered access. Thus, conflict management is integral to public health in complex emergencies: in terms of primary prevention as well as secondary prevention, if one wants to provide life-saving care in a context of violence: in Afghanistan like in DRC, Sri Lanka, Indonesia or the West Bank.

That is why WHO works at training health professionals in humanitarian law, political analysis, negotiation, etc, so to enhance their capacity to work in areas of conflict. *Being there* in spite of the circumstances is a strong testimonial of the absolute value of human life and *humanity* also in complex emergencies. WHO's stake in peace and

[1] Gro H.Brundtland, World Health Assembly, Geneva, May 2002
[2] WHO: Humanitarian Cease-fires Project. www.who.int/disasters/
[3] see www.who.int/disasters/ ibid.

humanitarian access stems from its mandate. Furthermore, WHO represents also a community of professional peers from all Member States in the World, that share principles of medical ethics, public health concerns and knowledge. This provides a useful platform for political dialogue at global level,.

**Health as a Bridge for Peace in Indonesia**

In Maluku, WHO commenced operations in Ambon in March 2001, working on drug supplies and management, disease surveillance, health manpower development and trying to facilitate inter-community dialogue and collaboration around health priorities. In June 2 the international staff had to be evacuated due to deteriorating security. However, the main activities continued to be carried out by local health authorities through the working groups set up jointly thanks to WHO's brokerage.

At field level, the principle of equitable, unhindered access needs to be integrated by clear vision, shared values and common priorities for action. It must be supported by sound logistics and operational coordination, complemented by long-term perspective of strategic planning. It needs good understanding of the potential synergies between sectors and strong partnerships between local and international actors.

*Reaching the vulnerable* is always difficult. It may appear easier in the aftermath of natural disasters. However, we know that there is no purely "natural" disaster: there are natural *hazards*, which impact upon human *vulnerabilities* that are mostly due to human causes, by commission or by omission. A degree of political analysis and negotiation is always necessary: the poor, the most vulnerable to an earthquake or a cyclone, often risk to be also left behind in the rehabilitation phase.

**Vulnerability**

The character of extreme events is determined not simply by some set of characteristics inherent in the physical phenomena (e.g., a hurricane, monsoon rains), but by the interaction of those characteristics with other systems (e.g., impoverished communities living on denuded mountains slopes in Nicaragua, or on huge garbage dumps in the Philippines).

Understanding vulnerability must take into account the context-specific nature of risks and shocks, and the capacity of individuals, households and communities to manage such risks.
( Sarewitz and Pielke Jr, 2002)

Thus, in the context of natural disasters, WHO sees "reaching the vulnerable" mainly as preventive action. Investigating the factors of vulnerability, enhancing the resilience of people, reducing their exposure, promoting equity and healthy livelihoods - *before and after* an extreme event - are all major parts of WHO's cooperation work with national and international partners at country level..

The stakes are much higher in complex emergencies. In these contexts, reaching the vulnerable means deploying humanitarian staff to dangerous and often isolated trouble spots around the world, where they risk disease or injuries too. The UN and its partners have faced many tragedies. The theme of the Consolidated Appeals for 2002, "Reaching the Vulnerable", highlighted both the need for access to civilians trapped by conflict, and for improved security for relief personnel.

Securing access to the vulnerable in war-torn areas calls for exceptional arrangements and procedures. Negotiating for humanitarian access is fraught with difficulties and expensive: there is anecdotal evidence from Colombia that different process of negotiations with armed groups can double the costs of delivering health care. This sort of human and financial investment must be cost-effective: i.e. it must be sustainable and make a true difference on the determinants of people's survival and health.

All efforts to reach the vulnerable must be backed up by the systems that can make the access more sustainable and useful. In WHO's view, arrangements for forward control,

communications, security, warehousing and transport for food aid need to be integrated at least by infrastructures for nutritional rehabilitation and health referral, not to mention the cold chain: immunisations is a well known life-saving intervention in complex emergencies.

**The vulnerability of national staff**

Already in 2001, WHO had alerted the ECOSOC to the fact that supporting national -or refugee- health workers is key to relief and to the preservation of local capacities. WHO also called for more attention to issues of *local human resources management*, for progress in the practice and outcomes of humanitarian programmes. Today, an Afghan doctor working for the new Ministry of Public Health earns 25 US$ per month, of which 20 US$ are paid in food vouchers.

This backstopping needs to take full advantage of the local systems. No matter how poor or disrupted, they are key to the humanitarian endeavours, and need to be supported. Synergies must be found and fostered between the local and the global system of relief. We know that the first to respond to any crisis are the people affected: if they do not cope, there is nobody for the external aid to assist. The capacities of local people and systems are key to humanitarian work, at least as much as inter-sectoral collaboration. WHO sees this everyday, from Afghanistan to the DRC: humanitarian assistance cannot do without the goodwill of its local partners.

Among those whom we have to reach, some are especially vulnerable. The children come first to mind, and the women, particularly the poor. However, from a public health perspective, one should be quick to add the elderly, the disabled and the chronically ill. More in general, in situations of distress, especially vulnerable are all those who have no means to cope with fast changes.

**The disabled**

WHO estimates that up to 10% of the world's population has a disability, and the majority of them, about 80%, live in developing, more disaster-prone countries. Furthermore, persons with chronic diseases and disabilities have special vulnerabilities. It is well known that Sub-Saharan Africa accounts for almost 70%of the global burden of HIV infection. Afghanistan and Angola show tragic figures of landmine amputees, etc. However, also lack of drugs and maintenance systems for chronic cardiovascular, kidney and respiratory affections, diabetes and mental patients, as seen during the long crisis in the Balkans and recently in the West Bank, can be cause of serious concern.

The vulnerability of individuals or groups is not a pre-fixed, static condition. WHO tends to agree with those who see vulnerability as a process, a progressive "loss of well-being": first psychological and economic insecurity, then increasing physical suffering. All along this process there are points where humanitarian assistance, supported by public health information and guidance, can complement the individuals' and the community's caring and coping strategies, and reduce vulnerability. Thus, understanding the process of becoming vulnerable can be as important as assessing the degree of vulnerability[4].

**The elderly**

Until recently, emergencies were largely confined to countries with a young age-structure. Recent events in regions with an older age structure changed this and the numbers of older people affected is increasing. Figures of refugees and IDPs can hide the full extent of the problem. Often, the elderly and the disabled are too frail to move away from affected areas. Sometimes they have to be left behind while the rest of the community flees. In most societies, old age, disability, poverty and vulnerability are closely intertwined. Another major distinctive factor in older persons is that they seem to be equally - if not more - vulnerable to natural as well as man-made disasters. Traditionally emergency operations target other sub-groups such as children and women, Thus, lack of awareness and focus on the aged and the disabled may have contributed to a neglect of these groups.

[4] D Sarewitz, R Pielke, Jr. *Vulnerability and Risk: Some Thoughts From A Political and Policy Perspective* Discussion Paper prepared for Columbia-Wharton/Penn Roundtable on "Risk Management Strategies in an Uncertain World", April 2002

Identifying beneficiaries according to specific risk factors makes managerial sense, as it helps formulate policies and strategies, but it carries its risks. Defining vulnerability by pre-existing assumptions may or may not suit a particular context. It may induce gaps in the response, or hide some of the needs of a population.

Furthermore, it is one of the oldest lessons ever learnt by humanitarian assistance that nobody should be seen simply as a burden on a community or a programme: thus, it may be worth reminding that vulnerable is not synonymous with " helpless victim". We know that every individual's skills and knowledge constitute assets for a community. It is the distinctive mark of good relief to integrate and to build on these assets without losing sight of the immediate goal of reducing mortality and suffering.

**Addressing vulnerability**

**in the post-crisis transition**

The challenge is to establish linkages between the 'extraordinary emergency' and the 'ordinary vulnerability' of the weakest groups. For instance, in FYR Macedonia, in 1997-2000, WHO produced a health policy safeguarding equity, human rights and the integration of vulnerable groups that was supported by UNICEF and UNHCR: this helped promoting changes through visible field-level "demonstration programmes" against the segregation and social exclusion This approach required investing in capacity building and rehabilitation of facilities.

It may seem naive to try and promote participation and equity in situations of armed conflict, when the warring factions actively pursue inequity. However, emergencies can offer opportunities. It is WHO's experience, shared by some of its partners, that approaching immediate humanitarian needs in a medium/long-term perspective, e.g. working simultaneously for health relief and the reform of local health systems with national and international actors, can reduce vulnerability and facilitate the transition to a more equitable and sustainable recovery (see box).

Finally, another reminder: the most vulnerable are the unknown and the forgotten. We see now in Angola the scale of the needs of the populations previously inaccessible and unaccounted for. The experience in Afghanistan and DRC show that emergencies do not disappear if the world's attention shifts. There are major disparities in international emergency response. The "forgotten emergencies", those in low profile areas, suffer from a lack of international agency presence, under-resourcing and minimal media coverage. This is a major problem of the international aid system that needs to be urgently addressed.

*It is my belief that, all together, we have the know-how, the capacity and the commitment to respond effectively to these formidable challenges to our work in humanitarian crises. But we need to continue to work together, and event intensify our alliances, among ourselves as UN agencies, and with governments, NGOs, collaborating centres, the media, communities, families, committed private partners. We must keep in mind that in emergencies, lives are lost whether the TV cameras are there to remind us about it or not* ( G.H.Brundtland)

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# ECOSOC 2002 Humanitarian Segment

## WHO technical contribution to the Panel

## *The transition from relief to development in the context of complex humanitarian emergencies and natural disasters*

**New York, 16 July 2002**

*The approach to humanitarian needs must be medium to long term in its perspective*[1]

The main lesson that WHO has learnt in the last ten years about transitions in the context of complex humanitarian emergencies is that only peace reveals all the health needs.[2]. When inaccessible areas open up they release a "backlog" of public health needs long left unattended, typically flagged by measles epidemics. Demand for services increases as the expectations of communities, local authorities and external partners grow. Furthermore, cease-fires need special health support: for demobilisation, de-mining and return of refugees and internally displaced persons.

Another lesson, that applies also in the aftermath of natural disasters, is that re-storing the original health system is not necessarily the right choice. Caution is needed, as the systems that were in place before the conflict were part of its structural causes and rehabilitation must not recreate past vulnerabilities or, worse, inequities. Likewise, a hospital destroyed by an earthquake or a cyclone clearly needs to be re-built following different standards. Thus, when

**Afghanistan**

Afghanistan represents an "extreme" case of these challenges. Natural disasters have coexisted there with a long complex emergency, and military interventions are being carried out simultaneously with relief and recovery activities. Aid has long been politicised. The crisis of the health system must be analysed against this complex background. The system has dramatically fragmented. NGOs have their own networks, which grew separate from the local, weak or absent administration. More than 50% of the primary network may be owned and managed by NGOs.

With no central nor local administration, no sector policy yet and weak coordination mechanisms, deregulation prevailed: national staff get different incentives, separate procurement and supply systems coexist, different technical guidelines were developed, training curricula proliferated. It is common to find several NGOs supporting different wards of the same hospital. This system does not allow for economies of scale, and precious resources are wasted. To reconduct these networks into a unified system, linked to an administrative division of the territory, will require time, huge efforts and trade-offs. Without funds to manage, the capacity of the government to influence how resources are allocated, will grow slowly. In such an environment, the flow of donor resources risks to be unpredictable, undocumented, insensitive to context, driven by fashions and imported models.

Afghanistan is a case in point of the old saying that extreme situations require extreme remedies. However, choices made in the initial phase of transition will influence heavily the subsequent development of the sector. In post-conflict countries, institutional weakness limits the ability of ministries of health in influencing the formulation of an appropriate rehabilitation policy; donors and international financial institutions have wide space for manoeuvring.
( WHO, 2002 )

[1] Nigel Fisher, DSRSG, Pillar II, UNAMA, at the Afghanistan Support Group, Geneva 11 July 2002
[2] During the first, short-lived cease fire in Angola, it was common saying among humanitarian workers in Luanda that "*1991 was a food emergency, but 1992 is a health emergency*".

the health sector is required to re-establish coverage, since access to care is rightly perceived as a major factor of stabilisation, it also needs to re-think itself.

After conflicts, also capacity building can carry specific challenges: in Sri Lanka, for instance, we see that the protracted segregation of the country in two parts means that the younger generations know little of the culture, even the language of the "other side". This means that the professional integration of new national cadres will need to be thought in a new, cross-cultural learning frame.

All these burdens fall upon the national health ( and other) systems at the worst possible moment: when, however fragile to start with, they are further de-capacitated by lost assets and human resources, missed investments and collapsed cost-recovery. Information is scanty, cash is short, health-related essentials ( e.g. food, clean water or energy) are equally precarious, people's coping strategies are exhausted and external assistance often bides its time.

During the acute phases of an emergency, basic needs are clear and there is usually a consensus on what to do[3]. However, in the protracted crises or in post-conflict situations, consensus is far less obvious. Dilemmas of legitimacy and sustainability are intrinsic to these environments. But they are compounded by the contradictions and limitations of the prevailing aid instruments

Countries in post-conflict see a sudden flurry of pledges and strong pressures for quick strategic planning and major structural reform, definitely justified by the will to sustain peace. Actual disbursement of funds for reconstruction is in fact often slow, and remains low when compared to the aid flowing into countries not affected by conflicts, but there is a relative sudden expansion in spending, and the international actors often have disproportionate power on how it is spent and on what.

> In Cambodia, having remained at very low levels until 1991, aid became a vital source of support for the health sector once UNTAC came into force: by the period 1992-1995, it accounted for 75% of the total health expenditure.
>
> Similarly in Ethiopia, despite the government using the peace dividend to support the health sector, dependence on aid to finance health increased: by 1992 aid accounted for 46% of total health expenditure, compared with 29% in 1989.
> Macrae, 2002

Power goes hands-in-hands with responsibility. The reason why WHO feels the need to re-emphasise this (at least as far as the health sector is concerned), is self-evident, but too often ignored. The decisions taken in the transition have not only an immediate impact on people's survival in a critical period, but they also influence their long term livelihoods: ideally they should translate into sustainability and, in the long run, equity and social stability. Irrespectively of who sets the post-conflict agenda, it will be the nationals who will be called accountable at a certain point in time.

That is why the transition requires that the international community recognises a central authority and work through it. However, as new regimes are often contentious, and their administration and bi-lateral external relations always very weak, aid tends to be channelled through relief-type interventions. These tend to play in favour of a project-

[3] *...Analogies in relief practices have been identified in countries as different as Bosnia and Angola, leading to conclude that " relief operations are functionally blind to the specific conditions that confront them"* ( Pavignani and Colombo, 2000)

based approach. NGOs tend to dominate service provision, and key considerations of financing (e.g. fees for service) and supply systems (drugs, etc) are waived because of the extraordinary conditions. Experience from around the world suggests that rehabilitation in the health sector tend to concentrate on rebuilding the infrastructure and on supplying free medicines. Planning and managerial capacities, human resources in particular, their training and management tend to be downplayed. The most obvious and contentious issue is the contractual and professional status of national health workers, whose salaries are often below subsistence level.

**East Timor**

In East Timor Early in 2000 the Interim Health Authority was created with national and UNTAET staff. Team visits to all districts were carried out and a Joint Donor mission resulted in the Health Sector Rehabilitation and Development Programme, targeting the restoration of basic services and the development of the health policy. A Trust Fund was set up to channel aid, paving the way to a sector-wide approach (SWAp).

Under the coordination of the Interim Health Authority, NGOs prepared district health plans: emphasis went on sustainability, limiting the number of facilities and staff. The second health budget targeted the strengthening of ongoing services and the development of policy, regulation and administrative systems. Contracting out of NGOs services was implemented through a competitive process managed by the Ministry of Health.
(Tulloch, 2002 )

We all agree that peace is a process not an event. We know that making it sustainable depends on reshaping the relationship between societies, their governments and the international community. But we feel that it depends also, more down-to-earth, on having ex- (or potential) combatants recognise their stake in it.

Rehabilitation of buildings and increased provision of drugs can save lives and are important. But post-crisis transitions need structural, not only infrastructural interventions. And also the overall objective of international assistance needs to be structural: beyond saving lives one must work at re-building livelihoods.

The common structure adopted by donor agencies, split between development and humanitarian desks does not help either. As far as we know, only USAID[4], Sida[5] and DFID[6], so far, have departments or programmes addressing emergencies all along their life-cycle.

The fact is that whatever the channels of aid, and whatever the doubts regarding the new regimes, rehabilitation cannot maintain the same pattern as relief, lest it de-capacitates further the local systems.

The experience of WHO in East Timor and Kosovo, now enriched by the work on-going with national public health authorities and international partners in

**WHO: main lessons learnt from the health sector recovery in Kossovo**

- The roles of various key actors should be defined early in the process.
- (An external technical agency) should take on a direct governmental role as the lead policy organisation only in the most exceptional circumstances, when there is no existing legitimate governmental authority.
- The lead policy organisation should concentrate on policy development and coordination and should support the process of implementing policy developed by national and local authorities, if they exist.
- In addition, this lead agency could serve as a resource for implementing agencies in areas such as developing workplans, indicators, and monitoring and evaluation systems.
- The lead policy organisation should develop varied and multiple funding sources for this function so that it can be and be seen to be an honest broker in such situations. ( from Shuey at al, 2001)

[4] *Complex Emergency Response and Transition Initiative* (CERTI) http://www.certi.org/
[5] *Humanitarian assistance & conflict management* http://www.sida.se
[6] *Department of Conflict reduction and Humanitarian Assistance* DFID http://www.dfid.gov.uk/

Afghanistan is that UN technical agencies have a primary role to play. In transitions, they are the best placed to assist the new government as impartial brokers, in taking the lead for policy development and sectoral coordination ( or to lead directly, where no legitimate authority exists).

As far as health is concerned, WHO has learnt that a sector's policy framework with a vision of the future can channel humanitarian assistance into activities that contribute to development and reform of the health sector. Such policy framework is useful even before the transition, as it can conciliate the short term emergency relief with the general lines of rehabilitation and recovery. WHO's experience shows that planning for reconstruction should start as early as possible, in spite of the pressures of the "acute phase". In the first weeks of its presence in Kossovo, in the summer of 1999, WHO produced a two-pages policy outline that played and important role in directing emergency aid towards what would be relevant also at longer term.

Emergencies - be they conflicts or major natural disasters offer unique opportunities to reappraise systems and to set the basis for stronger development. Indeed, emergencies are extreme "endurance-tests" for policies, strategies, programmes, practices, partnerships and leadership. There is already a fair inter-agency consensus, conjured by ALNAP that underlines the need to integrate this learning function in mechanisms for operational coordination[7]. WHO subscribes to this vision.

By careful selection of the technical messages and the aid packages that it provides, the international community can promote planning already in the early phases of a crisis. and help bring about positive changes in the beneficiary countries. WHO experienced this directly, for instance, when dealing with tuberculosis control in the former Yugoslavia.

In its works for easier dialogue between national and international public health actors, be it through technical information, workshops, seminars, or simply routine health coordination meetings, WHO endeavours to give to local and international staff and organizations in the field opportunities to discuss on technical priorities and work more effectively together.

[7] *ALNAP ( Active Learning Network for Accountability and Performance in Humanitarian Assistance) is an international forum working to improve quality and accountability across the humanitarian system. The ALNAP Secretariat is hosted by ODI in London.* www.alnap.org

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World Health Organization
Cluster of Sustainable Development and Healthy Environments
Department of Emergency and Humanitarian Action

# Emergency Preparedness at National and Sub-national Levels

Adapted from Claude De Ville, PAHO/PED[1]

## 1. A multi-hazard approach to disaster reduction

Most countries tend to focus preparedness efforts only on one type of disaster. The reality is that any country faces a variety of hazards. Therefore, Emergency Preparedness and Response (EPR) at country level calls for a ***multi-hazard*** approach: this means that there needs be a single "mechanism" to coordinate, define priorities, prepare and respond to all types of disasters.

The health sector and the ministries of health have the most challenging and visible responsibilities in emergency response. Failure on the part of the health sector to be institutionally prepared is particularly costly, not only in terms of lives lost, but also technically and politically both for the ministry of health.

Also the health sector needs to adopt a multi-hazard approach. All MOHs recognise prevention, preparedness and response against epidemics as their core responsibilities: they know that in an outbreak they must take the lead. But *all* natural or man-made emergencies threaten human life and health ( see table). Therefore for all of them the MOH needs to be prepared and ensure that inter-sectoral efforts are integrated (and optimised) by essential public health action[2]

## 2. MOH: specific responsibilities, interests and advantages

The role of MOH within Disaster Management stems from its specific responsibilities but also its interests and advantages. The MOH has a leading role in

i. advocating for general reduction of vulnerability and working directly to mitigate the risk of damages to health and water facilities.
ii. contingency plans for health response in case of emergency
iii. training all health actors for disaster reduction and emergency management
iv. ensuring health coordination of response

Other functions, e.g risk mapping or education for public awareness are equally important for disaster reduction, but MOH/the health sector have no special advantage nor responsibility for the. They must take place, but MOH should limit its role at central level to advocacy and promotion of the health perspective.

Definitely, at all levels of MOH, specific resources - human and material- should be assigned to the reduction of vulnerability of the health infrastructures. This is not a luxury: the more vulnerable the country, the more important it is setting aside resources for mitigation and preparedness.

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[1] Emergency Preparedness at National and State Levels- presentation given at the Inter-country meeting on disaster preparedness, Bali, June 2001

[2] See WHO **Core Corporate Commitments**: I.e. life-saving public health measures that must be immediately implemented in any circumstance,

**3. MOH/EPR programmes**

EPR programmes are needed within the health sector to make a difference where disasters hit, I.e. at the local level. Local EPR programmes must have a multi-hazard scope. They must encompass, serve and lead the *entire* health sector: hospitals and public health institutions, private, governmental or NGO. PAHO/PED experience in the Americas points to two complementary approaches

i. training and awareness activities through workshops, courses, dissemination of material at central and local levels
ii. the establishment and institutionalisation of an administrative structure for disaster reduction within the health sector, generally sited in the MOH.

3.1. Health preparedness at community level is always an elusive goal and especially so in the presence of poverty and structural instability. However, before contemplating any initiative at community level it is necessary that the EPR programme be decentralised at sub-national[3] level. Always keeping in mind that poorly planned decentralization can cause additional difficulties, at sub-national level, the EPR programme should work at

i. mobilizing the sector for disaster prevention, mitigation, preparedness, response and early rehabilitation
ii. coordinating with other sectors
iii. coordinating and advocating for health vis-a-vis central authorities and donors

3.3.At national level, a strong programme for Health EPR is needed to provide overall support and guidance. It must have dedicated staff and budget, and easy access to decision-makers.

**4. WHO's role**

Disaster reduction needs to be seen as a core function of MOH. There is no quick-fix for disaster reduction, which is a process of investment in people and institutions. Financial and political investments are essential for a programme to have continuity and induce positive changes. This continuity of investment and efforts must be sustained in the face of competing priorities. On the part of WHO all this implies

i. *Supporting the development of Human Resources.* Training is an essential component of capacity building. WHO can ensure that opportunities exist through workshops or short courses that are current practice in all WHO regions, or through university training, following the experience in the Americas and the Philippines. It is worth exploring ways to introduce Emergency Management in the curriculum of faculties of Medicine and Nursing and Public Health Schools.

   Specific training activities can be defined for each element of 'Capacity building[4]': in terms of audiences ( i.e. policy makers, managers or operators), formats, objectives and main contents. Ideally, the training material should cover all that is relevant: from concepts such as hazard and vulnerability to practical procedures such as occupational safety, passing through coordination techniques and logistic management.

ii. *Supporting the development of Institutions.* WHO can do this by strengthening the disaster office/program in the health ministry and/or supporting its decentralization at sub-national level.

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[3] district, province, region, state, A.L.

[4] "Capacity", in the context of emergency management summarizes four major elements: a) information on the problem to be tackled, b) authority to act, c) plans, resources, and procedures for their application, d) partnerships. (WHO/EHA: TRAINING FOR EMERGENCY HEALTH MANAGEMENT- Preliminaries for a Consolidated Strategy, 1998)

Most of all, WHO can assist by promoting inter-agency collaboration. In order to bear fruits, the MOH/EPR programme needs the support of the national institution responsible for overall disaster management - be it the Prime Minister Office, the National Prevention and Relief Agency, the Civil Protection - and other actors in the public and private sectors. Making these partners aware of, and responsive to the meaning of *Health* and the role of the *health sector* in disaster reduction is a precise responsibility of WHO[5]. On certain issues, the health sector can be a catalyst for change, e.g. - as in the case of PAHO/PED- by promoting transparency and accountability by proper emergency supply management.[6]

iii. *Structuring WHO's country technical cooperation.* All disaster have a negative impact on health as defined in WHO's constitution and EPR needs to be integrated as a core function of WHO country office[7]. The structure of any institution needs to reflect its core functions. Therefore each WR should appoint one staff to act as focal point for all disaster reduction related matters – from prevention to response. He/she will have coordinating functions: technical liaison with MOH, other national and international partners in the health and other sectors, institutional memory, stimulation of involvement of all WHO professionals in disaster reduction, etc. Given the political dimensions of emergency management it is advisable that this staff be international or otherwise have appropriate status within the WHO Country Team. All other WHO staff members need to be aware that reducing the risk of disasters is everyone's responsibility in his/her area of competence and not the reserved domain of the 'focal point'.

In highly vulnerable countries, assigning a full time officer to preparedness/ prevention is essential. Equally essential is adopting adequate contingency provisions in WHO's country cooperation strategy and budget, e.g by mutually agreeing in advance with MOH which resources can be re-directed from regular programmes to respond in case of emergency. It seems short-sighted for a government and a development agency to have to mobilize millions of dollars for humanitarian response without committing themselves to improve the local capacity of the health sector to prevent and prepare for disasters.

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[5] WHA 48.2. *Emergency and Humanitarian Action*

[6] See SUMA

[7] Emergency and Humanitarian Action-Disasters, Emergencies and WHO.paper presented at the 2nd GPMG meeting, Geneva, March 2000 (Agenda Item 5)

**Table: Multi-hazard ..proach: Rationale for Preparedness Planning ..t the Health Sector**

| Type of Emergency | Primary Hazard | Primary Causes of Death & Illness | Main responsibility of the Health Sector | Risk of damage for the Health Network - personnel and infra-structures | Capacities needed | |
|---|---|---|---|---|---|---|
| | | | | | Technical | Support |
| **Epidemics of Infectious Origin** | **Known Disease** | Agent-specific | Alert and Assessment<br>Surveillance<br>Case Management<br>Outbreak Control | + | Epidemiology & DC<br>Medical/Nursing care<br>Environmental Health | Communications, Laboratory, Facilities & Supplies<br>Inter-sectoral collaboration<br>Funds |
| | **New Emerging Diseases** | Agent-specific | Alert & Assessment<br>IDENTIFICATION OF AGENT<br>Surveillance<br>Case Management<br>Outbreak Control | +++ | As above, plus field research, crash training of personnel, new, specific health education possibly Cordon Sanitaire | As above, plus access to more sophisticated Reference Centres, greater capacity for Isolation, special drugs or vaccines |
| **Emergencies by Other Natural causes** | **Mass Food Poisoning by Natural Causes** | Agent-specific | Assessment<br>Identification of Cause<br>Case Management<br>Information and education | - | Epidemiology<br>Medical/Nursing care<br>Education | Communications, Laboratory<br>Facilities & Supplies<br>Inter-sectoral collaboration |
| | **Drought** | Diarrhoea, Malnutrition, Any other cause, by decreased access to Health services and higher vulnerability | Need assessment<br>Disease Control<br>Nutritional Surveillance<br>Therap./Supplem.feeding | + | Epidemiology<br>Disease control<br>Nutrition | Communications. Logistics & Funds for Outreach. Supplies<br>Inter-sectoral collaboration and coordination of relief |
| | **Floods** | Drowning, Trauma, Diarrhoea, ARI, vector-borne diseases | Search & Rescue/triage<br>Need assessment<br>Disease control<br>Assistance in temporary shelters | +++ | Mass casualty Management<br>Env. Health/Vector Control<br>Health care in temporary shelters | Special Training for staff and volunteers<br>Inter-sectoral collaboration and coordination of relief |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Emergencies from Technological causes (contn)** | **Industrial explosion, fire, spill, radiation** | Blast, Trauma, Burns, Acute respiratory distress, suffocation, Agent-specific | Search & Rescue/Triage<br>Casualty Management | + | Mass Casualty Management<br>Specific Medical/Nursing care | Intensive care facilities<br>Hospital vulnerability assessment and reduction |
| | **Collapse of man-made structure** | Trauma, suffocation, drowning, other according to type of structure | Search & Rescue/Triage<br>Casualty Management<br>Assistance in temporary shelters | +++ | Mass Casualty Management | Intensive care facilities<br>Hospital vulnerability assessment and reduction |
| | **Failure of lifeline systems** | Any cause, by lack of critical support care<br>Trauma by crowd panic | Prompt back-up<br>Casualty Management | +++ | Mass Casualty Management | Hospital vulnerability assessment and reduction<br>Back-up systems |
| | **Mass Food poisoning by Human causes** | Agent-specific | Alert and assessment<br>Identification of Agent<br>Case Management | + | Epidemiology<br>Specific Medical/Nursing care<br>Environmental health | Toxicology<br>Special Decontamination facilities<br>Access to special Reference Centres |
| **Complex Emergencies** | **Armed Conflict** | Trauma, malnutrition, ARI, Diarrhoea, Measles, Meningitis, Vector-borne diseases | Need assessment and Advocacy<br>Disease Control<br>Nut. Surveillance & Select. Feeding<br>Injury Management | +++ | Epidemiology & Disease Control<br>Nutrition<br>War Surgery<br>Health Care in temporary shelters | Special Agreements & Procedures<br>War Surgery facilities/capacities<br>Safe Transfusion facilities<br>Coordination of International Aid |
| | **Mass Labour Unrest** | Trauma, any cause by lack of critical support care | Mass Casualty Management | + | Mass Casualty Management | Special Agreements & procedures |
| **Complex Emergencies (contn)** | | Blast, trauma, Fire, suffocation, etc other specific. (eg. Chems, Biol, Nucl) | Mass Casualty Management<br><br>Special care against specific agents | - | Mass Casualty Management<br><br>CD Outbreak control<br>Specific Medical/Nursing care for chemical and radiation outcomes | Intensive care facilities<br><br>Reference labs, experts, etc<br>Protective equipment and specific isolation/ decon-tamination facilities<br><br>Special coordination with security systems |

| | | | | | | |
|---|---|---|---|---|---|---|
| | **Refugee/ Displaced Influx** | Diarrhoea, ARI, Malnutrition, Measles, Meningitis, vector borne diseases | Disease Control<br>Nut. Surveillance & Select. Feeding<br>Assistance in Camps/Transit points | - | Epidemiology & Disease Control<br>Nutrition<br>Health Care in temporary shelters | Recruitment of volunteers<br>Outreach and supervision<br>Coordination |
| **Major Public Functions** | **State Visit** | Any: illness of state guests<br>Illness among spectators<br>Crowd incidents (stampede etc.) | Back-up for possible special, high-profile medical emergency Readiness for crowd incidents | - | Medical/Nursing care | Intensive care facilities<br><br>Special coordination with security systems |
| | **Pilgrimage** | Epidemic diseases<br>Illness among spectators<br>Crowd incidents (stampede etc.) | Disease Control<br>Readiness for crowd incidents<br>Back-up for increased demand | - | Epidemiology & Disease control<br>Environmental Health<br>Mass Casualty Management | Intensive Care facilities<br>Temporary outreach facilities |
| | **Mass Entertainment** | Illness among spectators<br>Crowd incidents (stampede etc.) | Back-up for increased demand<br>Readiness for crowd incidents | - | Mass Casualty Management | Intensive Care facilities |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Emergencies by Other Natural causes (contn)** | **Cyclone** | Trauma, Drowning, Diarrhoea, ARI, Vector-borne diseases | Same as above | ++ | Same as above | Same as above |
| | **Tidal surge & Tsunami** | Drowning, Trauma, Diarrhoea, ARI, vector-borne diseases | Same as above | + | Same as above | Same as above |
| | **Earthquake** | Trauma, suffocation, Burns Diarrhoeas,ARI, Vector-borne diseases | Search & Rescue/triage<br>Need assessment<br>Casualty Management<br>Assistance in temporary shelters | +++ | Mass Casualty Management<br><br>Health Care in Temporary shelters | Intensive care facilities<br>Hospital vulnerability Assessment and reduction |
| | **Landslide** | Trauma, Suffocation; Diarrhoeas,ARI, Vector-borne diseases | Same as above | + | Same as above | Same as above |
| | **Volcanic eruption** | Trauma, suffocation, burns, Acute Respiratory distress | Need assessment<br>Casualty management<br>Assistance in temporary shelters | + | Mass Casualty Management<br><br>Health Care in Temporary shelters | Intensive Respiratory Care Unit |
| | **Bush Fire** | Burns, Trauma, suffocation | Same as above | - | Same as above | Burn care facilities |
| **Emergencies from Technological Causes** | **Transport Incident (road, railways, air, sea etc.)** | Trauma, Drowning, Burns, suffocation | Search & Rescue/Triage<br>Casualty Management | + | Mass Casualty Management | Intensive care facilities |
| | **Fire in Human Settlement** | Burns, Trauma, suffocation | Search & Rescue/Triage<br>Casualty Management | +++ | Mass Casualty Management<br>Intensive care unit | Burn care facilities<br>Hospital vulnerability assessment and reduction |

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# STATEMENT OF THE WORLD HEALTH ORGANIZATION

## Economic and Social Council
## Humanitarian Affairs Segment
## 11-13 July 2001

Over the past year again, for an **unacceptable** number of people, surviving through extreme events, be they conflict, displacement, floods or earthquakes has become the predominant objective in daily existence.

Following landmark resolution UNGA/46/182, the World Health Assembly passed resolution WHA48.2 on Emergency Preparedness and Response, defining WHO's role as a founding member of the Interagency Standing Committee. WHO's responsibility is to focus on reducing the avoidable death and suffering that result from any natural or man-made disaster. As stated by many delegations, this responsibility can be met only in partnership in as much as WHO ensures that all concerned work with full awareness of risks and opportunities, on the basis of shared interests and at the best of their technical capacities.

The determinants of life and death in armed conflicts are well highlighted by different studies *inter alia*, in D.R. Congo. Health problems account for the largest part of the suffering, and most people die of preventable causes: malnutrition, linked to infectious diseases and simple childhood illness, HIV/AIDS, tuberculosis, not to forget deaths linked to pregnancy and childbirth.

At the same time, global interests converging around health provide unique opportunities. HIV/AIDS commands global attention as a global security threat and its transmission has been linked to the epidemic of conflict and sexual/gender-based violence we see affecting several continents. The need to eradicate polio from its last abodes provides resources for what is left of local health systems in countries ravaged by long wars. For WHO, there is a challenge to capitalize on this commonality of interests, between the international health and humanitarian communities.

As we know the relief efforts of one sector need synergy with the other sectors, we also know those first called to respond to a crisis are the people affected: if they do not cope, there is nobody for external aid to assist. Inter-sectoral collaboration and local systems capacity are key to all effective relief efforts. WHO sees it as its responsibility that health concerns are addressed in Consolidated Appeals, and that health sector contributions not only to relief, but also to preparedness and mitigation, are well coordinated. WHO fully supports coherence, collaboration and solidarity within Humanitarian Coordination and UN Country Team as well as IASC mechanisms.

WHO approaches human survival and health in a broad perspective that encompasses medical care, water, sanitation, nutrition, disease control, immunization, family, reproductive, and mental health. WHO aims to provide overall technical coordination and in addition assumes specific operational responsibilities such as health assessment and surveillance, and coordination with local and national health actors, particularly local and national health authorities. As an operational agency, we are evaluating and building on what we have learnt in the UN Administered Territory of Kosovo, East Timor, Democratic People's Republic of Korea, not to forget El Salvador and Gujarat.

Because nobody dies *"of a disaster"*; and people die of starvation, of measles, of obstructed labour, of bullet wounds, or renal failure from crush injury; by analyzing the causes of death, WHO aims to provide health information targeted to decision-making in the field. The value of this approach was demonstrated last year in the crises in the Horn and West Africa. WHO will expand this capacity, bring it closer to where the needs are, and thus make it more useful for humanitarian actors. An immediate case in point will be the DRC and the efforts being made by the international community to face the catastrophe largely determined in health terms.

WHO disseminates **public health practices** to ensure best technical performance from all working in the field. In the least twenty years, sound and affordable interventions have been identified for most health risks. In 2001, WHO worked with UNHCR, UNICEF, ICRC and the SPHERE Project to produce Health Library for Disasters on CD-Rom, jointly with PAHO. It contains more than 250 technical publications, spanning the spectrum of relief to preparedness and mitigation, and thanks to donor support, is being distributed free or at production cost.

Improved public health practice also facilitates **dialogue between national and international actors.** Together with NGO partners, WHO is looking into practical arrangements that would allow field workers to discuss local emergency health priorities on the basis of accepted technical knowledge and thereby help them to co-ordinate more effectively.

In this respect, support to national -or refugee- health workers is key to the preservation of local capacities, and we call for more attention to issues of *local human resources management*, for progress in the practice and outcomes of humanitarian programmes. This goes hand-in-hand with our interagency effort on the elderly in conflict and disasters, where we promote a vision of the elderly and other vulnerable populations, not just as victims, but also as key assets, including for efforts of humanitarian advocacy and to use health dynamics and interventions as bridges towards peace and reconciliation, as well as rehabilitation.

In this humanitarian segment, it is good to emphasize the reactions of people caught in disasters are normal reactions to extra-ordinary situations, but they may cause new instability and new hazards. The **psychosocial aspects of disasters** cannot be reduced to a matter of mental health, but there is a need to better understand them and at the same time respond to the best of our ability. WHO sees action in this area as a necessary contribution by public health to humanitarian assistance. WHO convened in October 2000 in Geneva with UNHCHR and UNHCR as well as RSG/IDP, an 'International Consultation on mental health of refugees, displaced and other populations affected by conflict and post-conflict situations". This Consultation endorsed the 'Declaration of Cooperation on mental health of refugees, displaced and other populations affected by conflict and post-conflict situations', hereby referred to ECOSOC.

In closing, WHO congratulates the Emergency Relief Coordinator for his intervention at the beginning of the segment, and thanks the other agencies and NGO partners, members of the IASC, as well as ISDR for their effective collaboration, in testimony to the tenth anniversary of UNGA 46/182.

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World Health Organization
Cluster for Sustainable Development and Health Environments (SDE)
Department of emergency and Humanitarian Action
Emergency Health Intelligence and Capacity Building

# Public Health Learning for Emergency Coordination

**Program brief, January 2002**

One of WHO's strategic goals is to facilitate the dialogue between national and international actors on the basis of internationally accepted guidelines.

Three projects have been developed to improve best public health practices for humanitarian assistance and disaster reduction, which are included in this document.

1. The Emergency Health Library Kit
2. The Health Library for Disasters, a virtual library
3. Learning for Coordination - survey and a programme for the field

World Health Organization
Cluster for Sustainable Development and Healthy Environments (SDE)
Department of Emergency and Humanitarian Action
Emergency Health Intelligence and Capacity Building

# EMERGENCY HEALTH LIBRARY KIT

*Health data and public health guidelines are the best lubricants for coordination*

With the goal of reducing avoidable death and suffering caused by disasters, one of WHO's strategic objectives is to facilitate the dialogue between national and international actors on the basis of WHO and/or internationally accepted guidelines.

The Department of Emergency and Humanitarian Action (EHA) has selected a number of key guidelines on best public health practices for humanitarian assistance and disaster reduction, composing the Emergency Health Library Kit (EHLK).

Upon request the EHLK can be provided to agencies working in the field during emergencies. The Kit contains essential documents related to Public Health in Emergencies and it is intended to provide technical guidance to agencies operating in the field. The EHLK follows the model of the Blue Trunk Library, a WHO library project, providing basic health and medical information to district health teams in developing countries.

Each EHLK comes in a metal trunk, which can be used as a bookshelf. It contains 150 documents: guidelines and reference manuals produced by WHO, other UN organizations, and external publishers. Summaries of the contents of EHLK with detailed information can be accessed at the web address: http://www.who.int/eha then click under Publications to look for Bibliography. The cost of each Kit amounts to US$ 2300, transportation costs excluded.

So far, the Kits have been distributed through various WHO offices, and Universities, including East Timor, Indonesia, Kosovo, Mozambique, North Caucasus, Ethiopia and South Sudan. EHA has a number of kits ready for shipment on request. The contents of the Kit is regularly updated.

For further details please contact WHO/EHA at: eha@who.ch.

World Health Organization
Cluster for Sustainable Development and Health Environments (SDE)
Department of emergency and Humanitarian Action
Emergency Health Intelligence and Capacity Building

**Health Library for Disasters**

**The Global Virtual Library of Essential Information Resources on Public Health for Disasters and Complex Emergencies**

*Health data and public health guidelines are the best lubricants for coordinaton.*

One of WHO's strategic goals is to facilitate the dialogue between national and international actors on the basis of internationally accepted guidelines.

The Department of Emergency and Humanitarian Action (EHA) and the Disaster Programme of the Pan American Health Organization (PAHO/PED) have produced a CD-ROM on best public health practices for humanitarian assistance and disaster reduction, with grant assistance from DFID.

In 1999 PAHO/PED produced a similar CD-ROM. EHA had selected a Bibliography of Public Health guidelines for Humanitarian Assistance, part of which are already available to member countries and international agencies through WHO's Emergency Health Library Kits. Now, these two experiences are merged into a new CD-ROM, that contains more than 250 technical publications dealing with disaster reduction and best public health practices that are relevant to humanitarian assistance.

The contents of the CD-ROM were selected through a consultation that brought together with EHA and PAHO/PED all WHO technical departments at HQ and regional levels, as well as other UN agencies-UNHCR, HCHR, UNICEF, ICRC, the SPHERE project, Non-governmental organizations such as OXFAM, WHO collaborating centers such as the Center for Disease Control and Prevention (CDC-Atlanta), the Center for Research in the Epidemiology of Disasters (CRED- Bruxelles) and academic institutions like Tulane University.

Web publishing is substantial to this process. This electronic library composed of technical and scientific disaster information sources and resources which is selected for its technical value and quality, is also accessible on the Internet. Thus, initiative will be transferred and made available to the millions of end-users free of charge without any limit on time and space.

Summaries of the contents of CD-ROM can be accessed at the web
Addresses: http://www.who.int/eha and at http://www.paho.org/english/ped/pedhome.htm
The complete collection can be viewed at http://www.helid.desastres.net

The CD-ROM will be distributed by WHO and partners agencies, partly free of charge, partly at recovery cost.

The world of disaster reduction is constantly changing and expanding. To confront this reality, we are using state-of-the art electronic information technology to contribute to make available the most complete and up-to-date material possible. This first CD-Rom opens a process which will be evaluated, replicated and updated in the future.

For further details please contact WHO/EHA at: eha@who.ch. or PAHO/PED at disaster-publications@paho.org

World Health Organization
Cluster for Sustainable Development and Health Environments (SDE)
Department of emergency and Humanitarian Action
Emergency Health Intelligence and Capacity Building

# Learning for Coordination

# Public Health Guidelines in Emergencies

Joseph Mailman School of Public Health/Columbia University

World Education

## The Challenge

In emergencies, national authorities have the prime responsibility to respond to the needs of the affected population. However, especially in protracted crises and/or complex emergencies, the situation can often deteriorate to a degree that undermines fatally the capacity of the Ministry of Health or local authorities to meet the urgent public health needs. National efforts must then be supported by international relief workers.

A rapidly changing environment, weak coordinating mechanisms, unclear roles and responsibilities among the aid agencies, and little understanding of the affected country or region's overall problems and priorities characterize almost all the emergencies particularly in the early stage. Supplies may arrive in a haphazard manner and they may not be appropriate to the situation. Issues of security, sovereignty, language, culture, and differing ways of understanding the problem are compounded by a sense of urgency and the need to "do something quickly" to respond to the emergency.

In these situations, coordinating public health programs that respond to the real needs is difficult at best. Creating an environment in which field staff agree on technical priorities and work as a team, and organizations co-ordinate effectively together is a critical challenge. Tired, stressed relief workers, little time to think and plan, inaccurate and incomplete information, language and cultural barriers; all these need to be overcome for effective co-ordination to take place.

It is as a first step in this direction that in 1999 WHO started producing an Emergency Health Library Kit (EHLK) containing essential documents related to Public Health Management in Emergencies and intended to provide technical guidance to humanitarian field workers. So far, the EHLK has been distributed through various WHO offices, including East Timor, Indonesia, Kosovo, Mozambique, North Caucasus, Ethiopia and South Sudan. Also some international NGOs and institutions requested and received Emergency Health Library Kit to use as the reference material for their field staff.

However, experience shows that , in order to be more widely and resourcefully used by the relief workers, the Kit needs complementing with a training component that must fit in the difficult circumstances described above.

**The Response**

World Health Organization, Columbia University School of Public Health and World Education feel that the response should consist, at least for protracted crisis and complex emergency such as Kosovo or West Africa, in a flexible programme, that would act as a laboratory for relief workers to come together in structured learning settings to discuss principles and best practices, and thus contribute to health emergency coordination. This "Laboratory" would provide with the opportunity to identify resources and priorities, define roles and responsibilities, and give practical, hands-on experience in planning and coordination. A prime source of technical references would be the WHO Emergency Health Library Kit.

The personnel to participate in this program will be mostly national district level health workers who have good knowledge of the local epidemiology, state of health services and evolution of the emergency, and the international aid workers who arrive with more up-to-date knowledge and experience of other emergencies .

The major challenge is how to make of this learning activity a welcome tool that *facilitates* coordination, rather than an additional task for overburdened workers.

**Research; data collection and analysis**

The team from Columbia University School of Public Health and World Education have gathered information about current practices in public health coordination in emergencies. The main purpose was to identify whether the ideas expressed above could be developed into a field mechanism for co-ordination and support to best public health practices.

The data collected assisted the Columbia/World Education team to design a highly flexible program adjusted to the particular needs of relief workers in an emergency situation. They will also help assess the capability of relief workers to select and use WHO's and other guidelines and to apply them in different situations.

**Designing the syllabus and the delivery system**

On the basis of the results of this research, Columbia/World Education has prepared a syllabus for training of local and international health workers at the field level in complex emergencies and/or protracted crises. The syllabus explicitly aims at promoting dialogue in the aid community and at improving users' knowledge and skills in co-ordination and utilization of reference resources.

Columbia/World Education will also design a flexible, motivating delivery system that can fit to the circumstances at hand, respond to the needs of the participants. The design of the delivery system will include a set of indicators for the evaluation of the program.

**Proposal for developing the training resources**

The syllabus with the basic contents of the training modules and the proposed delivery system is being discussed between Columbia/World Education, WHO, the Active Learning Network for Accountability and Performance (ALNAP) members and partners at field level both in and outside WHO.. Once there is agreement, the team will prepare a proposal for programme implementation that will cover the costs of

1. developing the training modules and the materials for both the training of trainers course to prepare a core group of facilitators and training at the field / country level.
2. Conducting the trainer's training course
3. Advertising and marketing the programme
4. Organizing at least two pilot courses at field

We expect that by the end of the program, participants will be able to:

- be familiar enough with the contents of the Emergency Health Library Kit to be able to use it quickly as a resource reference and training/briefing materials.
- effectively utilize the available reference resources, EHLK and others for better management in emergency relief operations
- improve the co-ordination of health relief activities among the actors at the field / country level

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# DEFINITIONS

**For reference only.**

## Disaster:

- *an **occurrence** disrupting the normal conditions of existence and causing a level of suffering that exceeds the capacity of adjustment of the affected community.* ( UNDMTP, 1992)

- *a serious disruption of the functioning society, causing widespread human, material or environmental losses which exceed the ability of affected society to cope using only its own resources. Disasters are often classified according to their natural cause (natural or man-made).* (DHA, 1992)

## Emergency:

- *a **state** in which normal procedures are suspended and extra-ordinary measures are taken in order to avert a disaster.* (WHO, 1992)

- *sudden **state** of danger, etc. requiring immediate action.* (Oxford Pocket Dictionary, 1992)

## Complex Emergency:

- ***situations** featuring armed conflict, population displacement and food insecurity with increases in acute malnutrition prevalence and crude mortality rates.* (CDC-Atlanta)

- *a humanitarian **crisis** in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single agency and/ or the ongoing United Nations country program.* (IASC, December 1994)

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World Health Organization
Cluster for Sustainable Development and Healthy Environments (SDE)
Department of Emergency and Humanitarian Action
Emergency Health Intelligence and Capacity Building

**Programme Brief, October 2000:**

# Developing WHO's evaluation function in emergencies

Monitoring and evaluation ensure feedback to management systems. Evaluation contributes to transparency and accountability. It has a positive impact on the entire management cycle: the evaluation approach has implications for needs assessment and planning, as well as for monitoring and reporting. Evaluation also provides technical insights for best practices and informed decision making. Furthermore, evaluation is an important tool for institutional learning: sharing evaluation findings benefits the entire humanitarian community and can improve outcomes for affected populations. Developing evaluation methods that are tailored to public health in emergencies will directly and indirectly benefit all WHO's partners.
Therefore, with the overall goal of improving the health sector performance in disaster reduction and humanitarian assistance, WHO wants to develop its evaluation function as an integral part of its responsibilities in emergencies.

The Organisation wants to improve its own performance for the benefit of the affected populations, provide additional tools for public health management and increase its accountability vis-à-vis member countries and international partners.

For the above, WHO Department of Emergency and Humanitarian Action (EHA) will develop an evaluation framework in collaboration will all concerned parties and then pilot test it in 2-3 countries. Opportunities for training will be facilitated for staff from WHO and member countries, so to develop their evaluation capacity. Furthermore, WHO will strengthen its support to global efforts in the area of quality assurance, learning and accountability for humanitarian action.

Activities will be implemented by a dedicated officer posted in EHA/HQ, in collaboration with other WHO technical departments, regional and selected country offices. Links will be ensured with EHA advisory bodies like the Advisory Group on Research in Emergencies (AGRE), the Inter-agency Medical/Health Task Force (IMTF) and networks like the Active Learning Network on Accountability and Performance (ALNAP). The activities are expected to produce:

- A policy paper outlining WHO's specific evaluation needs in emergencies
- A framework and procedures for evaluating public health programmes in emergencies
- Training materials targeted at public health staff in emergencies
- Technical recommendations to improve planning, monitoring and reporting
- Health professionals, from WHO and other bodies trained in evaluation methods

Costs are tentatively estimated around 370,000 US$/year. Start-up activities are planned over two years. The annual plan of work and quarterly progress reports will be available on request from EHA. A programme evaluation is foreseen at the end of the first year.

For further details please contact WHO/EHA at: eha@who.ch.

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# *Internally Displaced Persons, Health and WHO*

**Paper presented at the Humanitarian Affairs Segment of ECOSOC 2000**
New York, 19-20 July 2000

## EXECUTIVE SUMMARY

Estimating the number of internally displaced persons (IDPs) is difficult, but global figures are enormous: over 20 million at the end of 1999[1]. World wide, the number of IDPs surpasses the number of refugees.

Displacement exposes IDPs to new hazards and accrued vulnerability. These dynamics result in greater risk of illness and death. Often, access of IDPs to health care and humanitarian assistance is deliberately excluded by conflicting parties. Furthermore, the arrival of IDPs can strain local health systems and the host population ends up sharing the sufferings of the internally displaced. Health outcomes are dismaying. A recent survey in eastern D.R.Congo[2] found that the fighting there resulted in at least 1.7 million excess deaths between January 1999 and May 2000 and concluded that, in such context, "*war means disease*". In other cases, dramatic increases in mortality rates for children U- 5 and maternal mortality have been documented. Polio eradication and malaria control face daunting challenges in countries undergoing complex emergencies, and HIV/AIDS is of paramount concern.

From a health perspective, the best option is to avoid human displacement. WHO contributes to the prevention of displacement by working for sustainable development. Placing health high on the political agenda helps maintain stability and thereby reduce the likelihood of displacement.

Primary responsibility for assisting IDPs, irrespective of the cause, rests with the national government. Nonetheless, the conditions under which assistance can be delivered in the case of a drought, for example, are far different from those prevailing in case of armed conflict. In any situation, though, only dialogue between national and international actors can improve the understanding of the health issues concerning the IDPs. All primary humanitarian concerns are based essentially on survival and health issues, and health can provide the best "lubricant" for inter-sectoral co-ordination: standards, guidelines and measures of effectiveness.

There is consensus among WHO's partners that, in emergencies, the Organization must:

- Take the lead in rapid health assessment, epidemiological and nutritional surveillance, epidemic preparedness, essential drugs management, control of tuberculosis, HIV/AIDS and sexually transmitted diseases, physical & psychosocial rehabilitation;
- Provide guidelines and advice on nutritional requirements and rehabilitation, immunisation, medical relief items, reproductive health[3].

If the vital health needs of IDPs, i.e. security, food, water, shelter and sanitation, soap and household items are not satisfied, health services alone cannot save lives. Health care, though, is another vital

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[1] *At the request of the Inter-agency Standing Committee, the Norwegian Refugee Council is developing a database of information to track the numbers and needs of internally displaced populations.*
[2] *IRC: Mortality in Eastern DRC-Results from Five Mortality Studies. Prepared by Les Roberts, IRC Health Unit, 2000.*
[3] *EHA consultation with donors and collaborating agencies on the role of WHO in complex emergencies, Geneva, March 1997*

need. HIV/AIDS and tuberculosis are common to any IDP context and, together with malaria, are difficult to tackle. Reproductive health has become a primary concern, the same as mental health. However, IDP situations occur mostly in developing countries and major causes of mortality can be prevented by low-cost public health priority interventions such as measles immunisation[4].

Community participation is essential and implies bolstering the assets and capacities of the beneficiaries. Under the principle of "doing the most for the most", WHO advises first addressing vulnerability by area and only subsequently targeting specific groups.

As long as IDPs remain inaccessible and therefore not identified, nothing can be done to safeguard their health. In such contexts, WHO sees advocating and negotiating for secure humanitarian access as integral parts of public health promotion. Protection, access and informed response are critical for the survival of IDPs. Country expertise, human rights principles and best public health practices must provide the basis for humanitarian action. Parties to the conflict must be integrated in these processes.

WHO sees IDPs' predicament as a dynamic, progressive loss of health: first psychological and economic insecurity, then increasing physical suffering that forces them to flee in order to survive. Along this process, health relief can and must complement the IDPs' own coping strategies, while looking for durable solutions. Public health principles provide the basis for WHO co-operation with the member countries and its partners in the Inter-Agency Standing Committee to mitigate the plight of IDPs.

[4] *M. Toole Twelve lessons for public health in emergencies, paper presented at FICOSSER, Paris 1999.*

*'Protecting [internally displaced] persons.... is one of the most daunting challenges of our time. Whether the victims are forced into camps, choose to hide or merge into communities, they tend to be among the most desperate of populations at risk. Internal displacement .... denies innocent persons access to food, shelter and medicine and exposes them to all manner of violence.* [5]

## I. Context

*"Internally displaced persons (IDPs) are persons or groups of persons who have been forced or obliged to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights, or other natural or human-made disasters' and who have not crossed an internationally recognized state border"* [6]. Hard data on the numbers of IDPs do not exist, and estimates are difficult to make. Depending on the reasons that force people to flee, figures can seem amazingly high, e.g. in most natural disasters, or amazingly low, e.g. in displacement due to civil strife. In the latter case, governments may be unable or even unwilling to acknowledge the existence and real numbers of IDPs. Sometimes the IDPs themselves do not wish to be identified for fear of persecution.

Nonetheless, global figures are enormous; the US Committee for Refugees estimated that there were over 20 million IDPs at the end of 1999[7]. Over 10 million of these were in Sub-Saharan Africa, and 1.9 million were in South America, mainly in Colombia. Other countries with large internally displaced populations include Iraq (almost 1 million people), Afghanistan (estimated 750,000-1 million) and the Russian Federation (1 million)[8]. Other persons are in an even more tenuous situation; they are not included in the figures above but they are sometimes mentioned as internally displaced, e.g. in the Middle East, the Philippines and South Africa[9]. Worldwide, the number of IDPs surpasses the number of refugees.

Contrary to refugees, IDPs enjoy no special status nor does any specific legally binding instrument guarantee them protection and assistance. For example, a recent study found that US legislation only "provides a minimal but not sufficient statutory basis" for Government action on behalf of IDPs[10]. Thus, of the forced migrants, IDPs are among the most vulnerable. Furthermore, in most circumstances it is the poorest and most vulnerable people who are forced to leave their homes or places of habitual residence by a natural or human-induced crisis.

As persons and citizens, though, IDPs are covered by the laws of their own country. International human rights law also remains applicable in cases of displacement. When the displacement occurs in the context of armed conflict, protection under international humanitarian law applies. Specifically, Article 3 and Additional Protocol II of the Geneva Conventions spell out essential principles of treatment of civilians fleeing an internal armed conflict, including protection and care for the wounded and sick. Special protection is set out for women and children[11]. The 'Guiding Principles on Internal Displacement'[12] set out the specific rights of protection and humanitarian assistance of IDPs and the obligations of governments in all phases of displacement. While not legally binding, these Principles, along with humanitarian and human rights laws, provide a framework for action.

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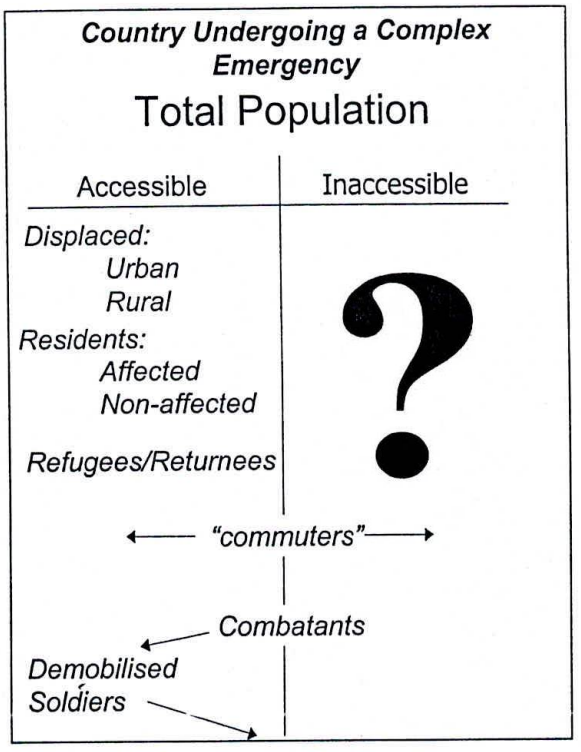
[5] *OCHA, Handbook for Applying the Guiding Principles on Internal Displacement, (pg i).*
[6] *OCHA, ibid (pg 6).*
[7] *IFRC, World Disasters Report, 2000.*
[8] *Norwegian Refugee Council Internally Displaced Persons Database. At the request of the Inter-agency Standing Committee, the Norwegian Refugee Council is developing a database of information to track the numbers and needs of internally displaced populations (http://www.idpproject.org/).*
[9] *Save the Children, War Brought Us Here, 2000.*
[10] *James Kunder: The U.S. Government and Internally Displaced Persons: Present but Not Accounted For. US Committee for Refugees, The Brookings Institution Project on Internal Displacement, November 1999.*
[11] *Lavoyer, Jean Philippe: Refugees and internally displaced persons: International humanitarian law and the role of ICRC, ICRC, 1 March 1995.*
[12] *OCHA, ibid.*

Especially tragic is the plight of those who remain inaccessible and are therefore not identified as IDPs; because of the location or the nature of the crisis, they get no public or institutional attention. This scenario is typical of complex emergencies, where there is little or no information on large areas and populations due to inaccessibility. It is a frequent finding - from Mozambique in the 1980s'[13] to contemporary D.R.Congo[14] - that before victims of war flee the most insecure areas, and thus get recognised as IDPs, they first try to cope by shuttling between their fields and houses during the day and hiding in the bush at night. Recent evidence suggests that this is a period of maximum risk [15].




In these situations of collective distress, some are especially vulnerable: the elderly, the very young, the pregnant women, the disabled, the chronically ill and, more in general, all those who are more recently displaced and haven't yet found ways to cope with their new condition.

Issues of protection, vulnerability and access are intimately linked. Additionally, for health and WHO, vulnerability is not a static condition but a complex process - in the case of IDPs, a very dynamic and rapid one. To approach and intervene in these dynamics, WHO suggests taking the IDPs' point of view on entitlement to protection and access to health.

## II. Internally displaced persons and public health concerns

Public health for refugees, internally displaced persons and other conflict-affected populations has evolved as a specialised field with its own policies, procedures, manuals, indicators and reference materials [16]. Displacement of a population always affects health status and health care. In the epidemiological triad of host, agent and environment interaction, displacement exposes IDPs to new hazard dynamics:

- Infectious agents and vectors might be present in the new environment, to which IDPs may lack immunity and or coping skills;
- In general, poor quality of water and sanitation and overcrowding, as in temporary settlements, modify interaction with existing infectious agents;
- Absolute and relative food shortages occur due to disruptions in the production and supply systems;
- Psychosocial balance is disrupted by being uprooted, insecurity, lacking meaningful employment, etc;
- Displacement can also lead to an increase in hazardous behaviours (e.g. promiscuity and sexual and/or intra-household violence);
- Weather vagaries and other natural hazards may be present in the new environment.

These new hazards are compounded by accrued vulnerability due to:

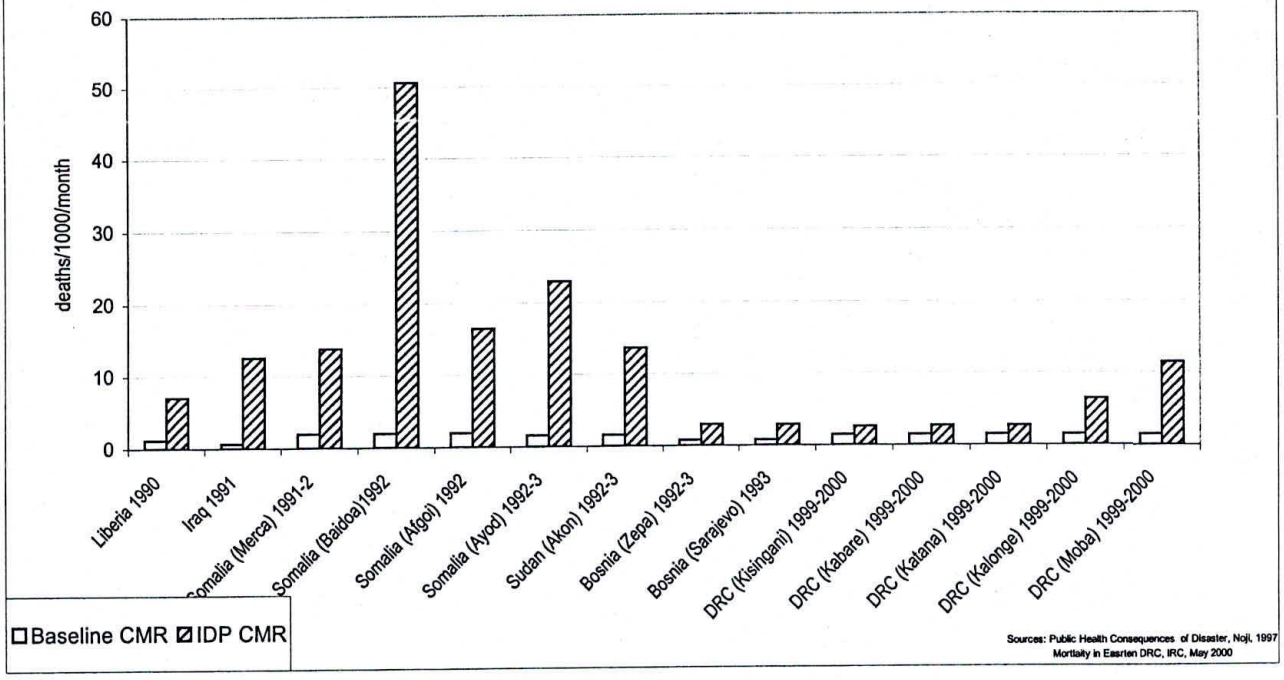
- Loss of assets and entitlements;

[13] *Personal observation, Mozambique 1988. Also in R.Geffray 1990 and K.Wilson, 1991.*
[14] *IRC: Mortality in Eastern DRC-Results from Five Mortality Studies. Prepared by Les Roberts, IRC Health Unit, 2000.*
[15] *IRC, ibid.*
[16] *M.Toole Twelve lessons for public health in emergencies paper presented at FICOSSER, Paris 1999.*

- Loss of social networks and caring capacities, often disruption of households. This has a particularly profound impact on women, children and the elderly;
- Lack of knowledge and information on the new environment;
- Decreased food security and dependence on external aid;
- Often inadequate shelter, sanitation and access to safe water;
- Reduced access to health care facilities and health care services: IDPs lose access to the health services they knew and are at a disadvantage, in cultural, financial, and functional terms in accessing health services in areas of relocation.

Exposure to new hazards and greater vulnerability result in greater risk of illness and death for these populations. Graph 1 compares crude mortality rates (CMRs) of IDPs with baseline rates. In most places rates for the IDPs are significantly higher than the baseline rates; in the most extreme case, Somalia, CMRs for internally displaced were 50 times the baseline.

**Graph 1: Crude Monthly Mortality Rates Internally Displaced Persons**




In April, 1999 Angola suffered the largest polio epidemic ever recorded in Africa. After 30 years of war and destruction of health infrastructure and services, massive population displacement - and the consequent over-crowding, poor sanitation and inadequate water supply - created an ideal environment for the spread of poliovirus.[17]

In Colombia, almost 2 million people have been obliged to move away from their places of origin to protect their lives. The situation is made more difficult by the fact that much displacement occurs "silently", and people simple merge unnoticed in the host population [18]. Only 22.1% of them are reported to have access to medical care[19].

Access can be made difficult simply by the fact that IDPs lack information on the availability of health services, their location or costs, etc. It can be argued that the high mortality rates often seen immediately after displacement (e.g. in Malawi in 1998) are also due to the time it takes for new

[17] *Taken from: Outbreak of Poliomyelitis – Angola 1999, MMWR, April 30, 1999 / 48(16);327-9.*
[18] *Fabio Rivas Munoz, personal communication, June 2000.*
[19] *Basic Country Health Profiles for the Americas, Summaries, 1999, PAHO.*

arrivals to find out where the services are located and how to access them[20]. But often, access of IDPs to health care and assistance in general - and of humanitarian workers to the IDPs - is deliberately excluded by parties in armed conflict.

Even in a best-case scenario, functional access is difficult and the host population shares the sufferings of the internally displaced. The arrival of a large number of people can strain local health systems that are not sufficiently resilient. If the new arrivals are unexpected, or if information is uncertain and slow, as it is often the case, personnel, supplies and facilities rapidly become inadequate. This translates into reduced access to health care and poor health outcomes for all. Internally displaced persons and host communities may also end up competing for access to food, infrastructures and environmental resources. In addition, IDPs may introduce diseases not normally seen in the host population. The hosts can perceive the IDPs themselves as a hazard.

In countries where armed conflicts are more prevalent and IDPs more numerous, health outcomes are dismaying. An International Rescue Committee (IRC) survey in eastern D.R.Congo states that the fighting there resulted in at least 1.7 million excess deaths between January 1999 and May 2000 and concluded that, in such context, "*war means disease*" and that "*violent deaths and non-violent deaths are inseparable*". IRC elaborates that the majority of deaths are the result of a combination of violence, lack of services, extreme vulnerability and "common" diseases, including trauma: the total number civilian deaths documented by the survey is "*directly attributable to the warring parties and their backers*", although in only 13% of the cases "*the mechanism of death was a man with a weapon*"[21].

In Burundi, the under-5 mortality rate increased from 108 x 1000 in 1992 to 190 x 1000 in 1998; in Afghanistan and Sierra Leone, maternal mortality rates are as high as 1,700 or 1,800 x 100,000 live births, respectively[22]. Polio eradication faces daunting challenges in all countries affected by conflicts or severe crises. Malaria is endemic in 80% of countries undergoing complex emergencies in Africa, Asia and Latin America[23]. The interactions between social instability, violent conflicts, human displacement and HIV/AIDS are of paramount concern. Sub-Saharan Africa, the region with the most IDPs is also the most severely affected by the HIV/AIDS pandemic, accounting for almost 70 percent of HIV-positive people and 83 percent of cumulative AIDS deaths[24].

## III. WHO and Internal Displacement

Health is a key factor in the growth of human capital, in disaster reduction and social stability. As part of its fundamental mission, WHO contributes to the prevention of human displacement through advocacy and technical co-operation for sustainable health development. Equity of access to health services and preventive care are essential to the reduction in hazards and factors of vulnerability. WHO also assists national authorities in designing health systems more resilient to crises and in building capacities for preparedness, so that local health systems can better adapt to the arrival of IDPs if displacement occurs.

This form of "health preparedness" can and should contribute to the prevention of human induced crises. Placing social services high on the political agenda can help maintain societal cohesion, national unity and stability. WHO's co-operation with member countries includes assessing the capacities and vulnerability of the health sector and facilitating consensus on priority public health interventions which must be ensured for everyone, even or more particularly in a case of emergency[25].

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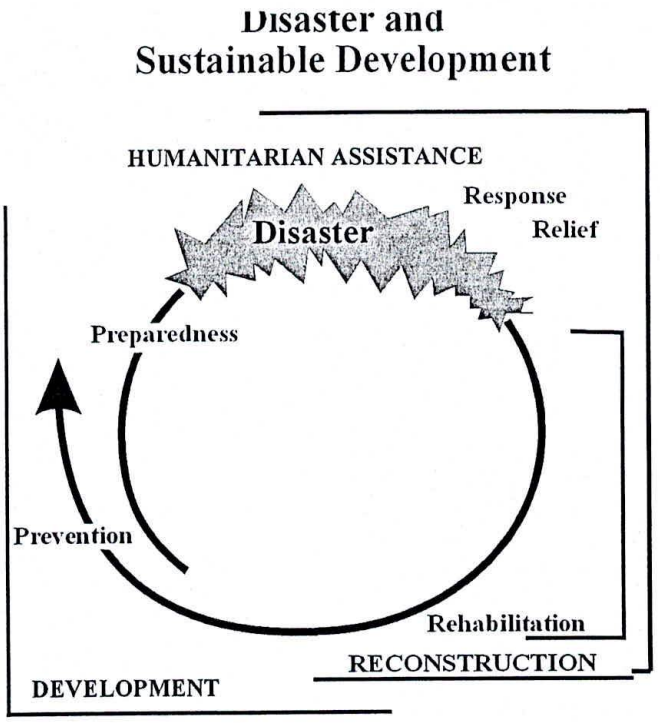
[20] *M.Toole. ibid.*
[21] *IRC, ibid.*
[22] *WHO/FCH: A health sector strategy for reducing maternal and perinatal morbidity and mortality by WHO and partners. January 2000.*
[23] *WHO/CDS: presentation at Partnership Meeting on Roll Back Malaria in Complex Emergencies, Geneva, June 2000*
[24] *Inter Agency Standing Committee-Sub-working group on HIV/AIDS in Complex Emergencies. Controlling the Spread of HIV/AIDS in Complex Emergencies in Africa. Geneva, May 2000*
[25] *'Planning Ahead for the Health Impact of Complex Emergencies, Draft Discussion Paper' WHO (EHA), 8 Dec 1999.*




Whatever these priorities, they have to take into account the possibility of internal displacement and to be flexible enough to be readjusted according to its dynamics.

Primary responsibility for assisting IDPs, irrespective of the cause of the displacement, rests with the national government. Unfortunately, while the core needs of IDPs may be similar, the conditions under which assistance can be delivered during e.g. a drought are far from those prevailing during a war or a violent conflict.

Even in the case of natural disasters, especially in developing countries, IDPs are the ones to suffer most. Most of the government's resources are absorbed by the emergency phase, leaving huge gaps when it comes to rehabilitation. Durable solutions for those displaced by the disaster may remain long unattended. In situations of natural disasters, WHO is well placed to facilitate and support health co-ordination because of its long-term presence in the country. Particularly building on health sector and programme preparedness, WHO uses evidence-based public health advice to facilitate understanding between the country and its international partners, co-ordinating and complementing interventions for health relief, recovery, health development and preparedness[26].

Most massive population movements, though, are connected with armed conflicts, and there, the authorities generally have very little capacity - and sometimes very little interest - to assist IDPs. They are considered a burden or an embarrassment, during and after a conflict. Worse, they can become pawns in the tactics of combat or even "means of production" in the economy of war[27].

In complex emergencies, WHO, as a UN specialised agency and an Inter-Governmental Organization, needs to reconcile its unique responsibilities in the health sector, the humanitarian imperative and the mandate to assist its primary constituent, the member state. As a government feels undermined in its capacities and legitimacy, co-operation with ministries of health and local health actors can come under strain. Work with national counterparts in general becomes more difficult, while access to national/local knowledge and capacities remains essential for effective action.

When governments are unable or unwilling to provide necessary aid to the IDPs, some of the needs are met by NGOs (local and international) and others by UN Agencies. UN co-ordination is assured by the Inter-Agency Standing Committee (IASC) through the system of humanitarian co-ordination. WHO participates and has been a full member of the IASC since its beginning in the early 1990's. Through the country offices of the various IASC participants, co-ordination is also assured within countries.

There is still much room for improvement. A recent WFP review[28] identified three main gaps in humanitarian assistance to IDPs:

- Protection gaps: in the absence of one agency with overall responsibility for the protection of IDPs, this remains an outstanding issue;
- Resource gaps: non-food sectors are often under-funded;

[26] *WHO/EHA: Emergency and Humanitarian Action -Disasters, Emergencies and WHO; paper presented at the Second Meeting of the Global Programme Management Group, Geneva, 17 March 2000.*
[27] *J-C.Rufin: Les economies de guerre dans les conflits de faible intensite, Defense nationale 1993.*
[28] *WFP IDP Review: Experiences with Internal Displacement, WFP, 16 March 2000.*

- Coordination gaps: there is a need to ensure a collaborative, coordinated approach to assistance to displaced persons.

Arguably, the first two gaps depend on variables that escape the direct control of those more closely involved. The "co-ordination gap", though, can and must be filled by national and international actors working together. All the experiences from the late 1980s onwards indicate that also in situation of displacement, highly effective outcomes may be achieved through active involvement of host government, utilisation of local skills and the insistence on accountability by relief agencies[29].

In WHO's mandate, it assists its member countries to attain and maintain the highest possible level of health for all their citizens, and displacement is not a qualifying variable in this respect. It is important to remember that in a specific country or situation the World Health Organization also represents the collective presence of all the other WHO member countries, and particularly the views and capacities of those countries' health sector. A privileged relationship with the ministry of health is central to WHO's presence, continuity and its function of global health exchange. In practice, though, the Organization recognises that the ministry of health is not necessarily the only or the most appropriate partner for its technical co-operation, particularly during emergencies. New partnerships are forged with other ministries, local or international NGOs, UN agencies and the military during emergencies. WHO's contribution is based on its technical and moral authority and its special relationship with its member countries. Within the context of the IASC, this gives the Organization a specific advantage to advocate for and work toward having:

- The existence and the health rights and needs of IDPs acknowledged;
- IDPs identified and counted;
- Humanitarian access ensured;
- External resources mobilised for health;
- Local health capacities identified and strengthened- be they institutional or community based;
- Public health best practices adopted.

For WHO, the most important and urgent need is for dialogue between national/local actors and international partners in order to improve the understanding of health issues in IDP situations. As all primary humanitarian concerns are based essentially on survival and health issues, for WHO health concerns provide the best "lubricant" for inter-sectoral co-ordination.

## IV. Principles for WHO Action on Health of Internally Displaced Persons

**Population figures** are key for planning and monitoring any relief operation and are the essence of public health, which is a population-based discipline. IDPs must be recognised and counted; this is not easy, particularly when IDPs are integrated with host families. However, for instance, health records (e.g. a sudden increase in vaccination coverage) can help identify "silent displacements". Simply by providing national data on figures and structure of population and by applying vital statistics and epidemiological tools, WHO can facilitate the definition of the beneficiaries, estimating their numbers and needs, and establishing monitoring systems.

The health of the IDPs is best preserved **through a community-based, preventive approach**, which is dependent on the satisfaction of the following vital health needs:

- Security;
- Water;
- Food;
- Shelter and sanitation;
- Clothes, blankets and essential domestic items; and
- Preventive and curative health care.

[29] *M.Toole, ibid.*

There is consensus among WHO's partners that, in emergencies, the Organization must:

- **Take the lead** in rapid health assessment, epidemiological and nutritional surveillance, epidemic preparedness, essential drugs management, control of tuberculosis, HIV/AIDS and sexually transmitted diseases, physical & psychosocial rehabilitation;
- **Provide guidelines and advice** on nutritional requirements and rehabilitation, immunisation, medical relief items, reproductive health[30].

For other vital needs, WHO is not primarily responsible. Nonetheless, as the UN technical agency responsible for health, WHO needs to advocate that *they be met by other agencies, lest preventable deaths occur*. The Organization can also provide the guidelines and information that can assist its partners in planning or measuring the effectiveness of their relief interventions. In all these instances, WHO's action is consistent with its core corporate functions[31].

i.) **Security** - from violence as well as from hunger and disease - is the IDPs' paramount need. Violence is a major cause of illness and death, directly and indirectly. WHO needs to ensure that war and other violence-related injuries are included in epidemiological surveillance - and advocates for proper care of the victims. For certain vulnerable groups like children and the elderly, security has more basic requirements, e.g. family reunification, which in turn impinges on programmes for mental health. Health education can include segments on violence, first aid training and injury prevention. Programmes for mine awareness and clearance, disarmament and demobilisation contribute to security. All need a health component to be co-ordinated with national counterparts, and WHO can provide support. Lastly, WHO has growing experience with programmes such as 'Health Bridge for Peace'(HBP)[32] in support of conflict resolution, peace-building and secure environments.

ii.) **Water** is vital. In emergencies, ensuring at least 20 litres of water per person/day is central to any strategy. Water supply programmes need to ensure adequate number and distribution of water points - the more users of a source, the easier the contamination - and that the community be empowered to maintain the sources and the quality of the water, e.g. by education and provision of user-friendly pumps, spare parts, buckets and chlorine. Besides providing guidelines on water safety and in some instance being directly involved in improving water supply, WHO also has its scientific authority to bring to bear, so that health data, e.g. number of cases of diarrhoea and skin infections, are used to monitor the effectiveness of assistance.

iii.) Minimum **food** requirements exist (2100 kcals/person/day) *below which no "health" is possible*. Internally displaced persons require the same quantity and the same range of nutrients required by all human beings. Supply-driven aid is ineffective and unethical[33]. Food aid programmes must ensure adequate quality and quantity of food is available to the entire affected population (as well as pots and fuel to prepare it). Food is either procured by the IDPs (i.e. by foraging, trading or market purchase), distributed through food aid or, most commonly, through a combination of both. Selective feeding provides only supplementary food to specific vulnerable groups and special food for those in need of nutritional rehabilitation; it cannot compensate for inadequate general rations. Ensuring that nutritional surveillance is in place, and that its

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[30] *EHA consultation with donors and collaborating agencies on the role of WHO in complex emergencies, Geneva, March 1997*

[31] *WHO core functions have been outlined as:*

- *Articulating consistent, ethical and evidence-based policy and advocacy positions;*
- *Managing information to assess trends and compare performance, along with setting the agenda for and stimulating research and development;*
- *Catalysing change through technical and policy support;*
- *Negotiating and sustaining national and global partnerships;*
- *Setting, validating monitoring and pursuing the proper implementation of norms and standards (best practise);*
- *Stimulating and testing of new technologies and tools and guidelines for disease control, risk reduction, health care management and service delivery.*

*(On 'Policy framework for programme budget 2002-3', WHO)*

[32] *The main purpose of the HBP programme is to identify and develop actions and strategies that can maximise the peace building effects of health programmes before, during and after conflicts.*

[33] *M. Toole. ibid.*

information is used to monitor food distribution is universally accepted as WHO's responsibility[34]. Guidelines for therapeutic feeding are another of WHO's responsibilities. Furthermore, disease consumes nutrients; only proper preventative and curative health care can optimise food aid.

iv.) **Shelter, sanitation** and the environment are primary determinants of health. Exposure can be a fatal hazard, especially for weakened persons; IDPs must have shelter, blankets and clothes. Shelter has also direct implications on the use of impregnated bed nets against malaria, while hygiene and good environmental management are generally needed to control vectors of disease. As with water, there are minimum standards for sanitation that are essential for people's health and dignity[35]. Good programmes need the full support of the beneficiary community that should be given responsibility and the means to fulfil it according to local norms and cultural acceptability. Again, WHO will provide the technical guidelines and measures of effectiveness for activities that are responsibility of sectors other-than-health but that have impact on the people's health status.

v.) If the other vital needs are not satisfied, health services alone cannot save lives. However **adequate health care is** another primary concern; IDPs are at increased risk of illness and death. WHO must ensure the public health component of assistance is technically sound. Some overarching principles apply[36]:

- The absolute priority is to keep, or bring the daily crude mortality rate below 1 per 10,000 population and the daily under-five daily mortality rate below 2 per 10,000 children less than five years old.

- Appropriate decision-making for health and nutrition in IDPs situations depends on reliable information and a focus on disease prevention and health promotion[37]. Rapid health assessment and epidemiological surveillance in such situations are responsibilities of WHO[38]. Establishing surveillance systems in IDP camps is fairly easy. It is much more difficult when IDPs are hosted by friends, families, volunteers etc - and often not properly registered. WHO sees its responsibility as facilitating integration between the national health information system, those set in place by external partners, e.g. international NGOs, and local structures, e.g. the national Red Cross/Red Crescent society.

- In the early 1990s, experience showed the most prevalent diseases in IDPs situations affect mainly children and are readily preventable or treatable[39]. The events in the Balkans and the patterns of illness prevailing among IDPs in Europe and elsewhere have triggered more thinking, especially in terms of public health measures for victims of violence, chronic conditions and equitable referral systems. HIV/AIDS and tuberculosis are infectious hazards common to any context and, together with malaria, the most difficult to tackle. Reproductive health is gaining more and more ground as a primary need, as is mental health. Nonetheless, the fact remains that IDPs situations occur mostly in developing countries and that major causes of mortality can be prevented by proven, low-cost public health interventions. Measles immunisation is one of these priority interventions[40].

- Community participation in a co-ordinated health programme is always an advantage in the provision of health and nutritional support services, and has a value in itself, particularly in terms of mental health. Community participation implies identifying and bolstering the assets and capacities of the beneficiaries. IDPs carry along their personal skills, and their coping strategies must be encouraged and supported. As a minimum practical step, WHO can and will

[34] *EHA consultation, ibid.*
[35] *The Sphere Project-Humanitarian Charter and Minimum Standards in Disaster Response. First final edition 2000.*
[36] *'First International Emergency Settlement Conference: New Approaches to New Realities, Emergency Settlements' April1996, University of Wisconsin – Disaster Management Center.*
[37] *M.Toole, ibid.*
[38] *EHA consultation, ibid.*
[39] *'First International Emergency Settlement Conference, ibid.*
[40] *M.Toole, ibid.*

insist with national authorities and international partners that any health worker among the IDPs has her/his qualifications recognised and made use of, including proper remuneration.

- Where those hosting the IDPs are also impoverished, in poor health and lacking food, assistance should reach all, both the displaced and the surrounding community. Under the disaster reduction principle of "*doing the most for the most*", it seems advisable to first address vulnerabilities by area and only subsequently target specific groups. Since the early 1990s, on the basis of experience gained in Central America and Southern Africa, WHO has been promoting community-based approaches that aim at empowering the host communities to assist IDPs [41].

## V. Operationalising the principles in WHO

*'Public health... can be effective only in as much as the security of victims of armed conflicts is guaranteed. Security embraces the sustainable satisfaction of needs and respects basic rights of human beings.* [42]

As long as IDPs remain inaccessible and therefore not identified, nothing can be done to safeguard their health. In such contexts, and in IDP situations in general, WHO sees *advocating and negotiating for secure humanitarian access as integral parts of public health promotion*. Possibly the most important task for WHO is to support local NGOs on the basis of humanitarian principles, because they are generally the ones that have the best access to IDPs. WHO's moral authority prompts it to act as an interface between the ministry of health and the local NGOs dealing with IDPs, minorities and special vulnerable groups.

A key element of preparedness planning and a priority for inter-sector/agency co-ordination is to identify trends, flows of displacement, points of passage, and most suitable (or likely) areas of shelter. This will allow assistance to IDPs *en-route* and preparation of local health systems to assist the newcomers. Furthermore, all plans should make contingency provisions for sudden increases originating from inaccessible areas, i.e. new IDPs carrying along a "public health backlog" of missed opportunities for ante-natal care, immunisations, etc.

Humanitarian co-ordination must bring UN agencies, national authorities and the military together with the Red Cross (ICRC, IFRC and national societies) and NGOs working in or near the conflict zones. It is at this stage that protection, access and *informed response* become critical elements for the survival of IDPs. Country expertise, situation analysis, human rights, vital health needs and best public health practices must be combined to provide the basis for planning, humanitarian diplomacy and for operational arrangements. Parties to the conflict - if that is the cause of displacement - must be integrated in these processes. WHO can contribute to humanitarian intelligence, negotiations, planning and monitoring with data from the country's health profile, public health standards, need assessment, epidemiological surveillance and direct technical assistance.

At a certain point IDPs become accessible and "visible". In some cases, IDPs are brought to a first reception/transit centre by soldiers, such as after a military operation. Another scenario is that IDPs gather spontaneously, for example by a source of water, a road or a city, and are met there by humanitarian workers. More often, individuals or small groups seek shelter with relatives or friends in a safer area; there they can be identified and assisted by volunteers, e.g. of the national Red Cross society. In most cases, they will at least be registered by local authorities for security purposes.

WHO must engage actively with the actors who are most likely to be the first to meet the IDPs, because it is they who can provide immediate, life-saving assistance. Preparedness is essential. Village

[41] *HEDIP-Health and Development for Displaced Populations, WHO/Emergency Relief Operations, 1993.*
[42] *P. Perrin 'War and Public Health: Extending the Concept of Public Health for the Victims of Armed Conflict', from Health in Emergencies, Issue 3, EHA/WHO, 1998.*

health workers, Red Cross volunteers, local administrators, even party cadres can help *pre-position assistance* close to inaccessible areas; at a bare minimum they can inform IDPs about which health services are available where and how to access them. Agencies such as UNHCR, NGOs and the military are the best placed to assist the IDPs in transit/reception centres. IDPs in spontaneous settlements can receive a degree of first, immediate health assistance, e.g. rescue teams can administer measles immunisation to all the displaced children they encounter. As health workers are often on the front line of assistance to IDPs, WHO advocates that they have the knowledge and skills needed to ensure that IDPs' health encompasses their right to security and protection. Therefore, in countries undergoing or at high risk of complex emergencies, WHO's programme Health as a Bridge for Peace focuses on training health workers in humanitarian law, political analysis, negotiation, etc.

This is health co-ordination in practice: working with national or local authorities, from health and from other sectors, with UN agencies and NGOs to ensure that all accessible areas can offer first health relief; monitoring that relief fits the IDPs' needs; ensuring that relief has adequate systemic follow-up and operational support; working for the IDPs to meet the security that comes from the sustainable satisfaction of needs and the respect of the basic rights of human beings.

IDPs concentrated in camps or in shanties around safe towns bring dramatic challenges to public health. As soon as possible, conditions of life must be improved by expanding and extending the existing health systems. Improved water supply, food security, sanitation, housing and health care delivery are essential. Keeping in mind the burden that the newcomers can represent for the host community, WHO needs to advocate for an integrated, area-based approach, rather than a vertical, vulnerable-group approach.

Also, in the Organization's experience, historical evidence provides a warning that only cases of extreme emergency justify parallel structures. Even if very strongly represented at local level, **all** external interventions rely on national capacities - no matter how weak - for back-up and support, e.g. hospitals, cold-chain systems or reference laboratories. For WHO, it is clear that international aid can be detrimental by hiring away local workers, duplicating services and creating a two-tier health system. In order to be immediately effective and then sustainable, external assistance needs to be co-ordinated, include local capacity-building and be carefully planned, so as to fit in the national systems.

Finally, if the medium-term perspective is to integrate IDPs in the host community, investment must include education and the creation of economic opportunities. If this cannot be done where the IDPs are concentrated, *then public health concerns justify that they are moved elsewhere.* Whether the crisis at the origin of the displacement is solved or not, decisions must be taken, lest the IDPs' plight is maintained indefinitely and, for instance, they become political hostages in peace negotiations. The choice is between the IDPs returning home, which will often require rehabilitation in the area of origin, or resettlement, which will necessitate investment in a new area. These are politically-loaded decisions. Again, WHO has a degree of responsibility to see that they are taken and wants to contribute on the basis of public health principles and its technical authority.

In rehabilitation and reintegration, caution is needed. Restoring the original health system is not necessarily the right choice; arguably, what that was in place before the crisis - be it armed conflict or natural disaster - was part of the structural cause of the displacement itself. Rehabilitation must not recreate those conditions. For instance, rehabilitation must take into proper account the needs of previously under-served, minority groups and ensure more equitable and appropriate access to health services. Furthermore, all major crises bring change; this is particularly true for violent conflicts. Even if damage to the infrastructure is limited, demographic patterns change, new social structures emerge and new economic options are needed. Even the natural environment may be permanently changed (e.g. by landmines). People will have new needs and, often, greater expectations. For some rural communities, the move into IDPs camps can represent an experience of forced fast urbanisation; for some of them, the first contact with health services.

## VI. Conclusion

All institutions risk reducing reality to what is covered by their mandate, or to what they are able to deal with[43]. In WHO's view, its mandate gives it a comparative advantage in looking at internally displaced persons: health is for all, not only for vulnerable groups. The fact that it is easier to assist IDPs once - and as long as - they are concentrated in a camp should not overshadow their dynamic predicament: a progressive "loss of health", first as psychological and economic insecurity then as increasing physical suffering that forces the person to flee. IDPs are individuals who must move to find new coping mechanisms and survive. All along this process there are points where health relief can be provided to complement the IDPs' coping strategies, while action is taken to find the durable solutions to which they are entitled.

No matter how dramatic or outright tragic, internal displacement is only a symptom of a wider public crisis. The challenges that instability pose to humanitarian and developmental work are many: the loss of legitimacy of national institutions, the difficulty of identifying critical stakeholders and negotiating between them, the contradictions that may occur between transparency and neutrality, differing agendas of the international community, e.g. economic sanctions imposed upon societies already affected by structural crisis, to mention just a few[44].

In addition to international health information exchange and liaison, WHO's mandate at country level is to increase the resilience of local/national public health systems through technical co-operation. During crises, the WHO country office must remain functional and be ready to advise on and adopt the most suitable strategies. Arguably, a key indicator of WHO's corporate performance is the way its country programmes withstand the impact of crises and international relief efforts and are able to accommodate new realities, such as IDPs.

Whatever the circumstances, WHO has the public health tools to ensure that the IDPs' vital needs are met, thus preventing further deterioration of their health status. The challenge for the Organization is to ensure that its country offices structure these instruments in strategies that are appropriate to the context at hand. Regional and country experiences provide some hints[45]. They point to the need for early intelligence and networking with a vast range of partners, for involving NGOs and civil society at large in dialogue with health authorities and making IDPs active stakeholders of health assistance. Another calls for the re-gearing of country technical co-operation, having all programmes remain active and collaborating to meet the needs of the IDPs and to ensure that once a crisis is over there will be no gap on the road to recovery. WHO offices can and must make their role in health co-ordination tangible by providing partners with the "learning functions", i.e. documentation and health intelligence that some indicate as essential[46,47] for **informed response** in emergency operations.

If it is true that, as the technical reference for health, WHO can facilitate co-ordination of all aspects of assistance to IDPs, then the Organization's mandate must be supported by presence and proximity. Predictability, health intelligence, proactive networking and services to its partners and constituents are at the core of how the World Health Organization exercises its responsibilities.

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[43] *James Kunder, ibid.*

[44] *EHA Inter-Regional Retreat, Neemrana Fort Palace, 28 February-2 March 2000.WHO/EHA , April 2000*

[45] *EHA Inter-Regional Retreat, ibid.*

[46] *M.Bhatt, M.Reddick Retrospective Model for Orissa Learning Office-Issues Raised and Lessons Learnt. Draft report for discussion at ALNAP meeting, London 6-7 April 2000*

[47] *E.Pavignani, S.Colombo June 2000 "Health as a Bridge for Peace. National Health Systems and Protracted Humanitarian Emergencies. Preliminary Findings from a Comparative Study on Angola and Mozambique. WHO/EHA, Geneva, June 2000*

***What worked in Colombia?***
***A case study from PAHO***

There are approximately 2 million Colombians deprived of normal access to health care due to continued displacement with the country. Overcrowded conditions mean basic water and sanitation facilities are inadequate.

AMRO/PAHO spearheads efforts to improve the quality of coverage of basic health care and sanitation for the internally displaced. PAHO is promoting new partnerships between NGOs, local authorities, local emergency committees and other health professionals so that all are working together to:

- Facilitate access to health care for the internally displaced by disseminating information on rights of IDPs;
- Develop standardised technical guidelines for local health personnel to ensure consistency, co-ordination and professionalism;
- Strengthen local health delivery mechanisms to improve the quality of emergency health response.

These activities illustrate how the humanitarian principles outlined in Section IV of this paper can be implemented. Access of the IDP to assistance, which has been highlighted as a major issue, is addressed by this project. Standardised guidelines, widely distributed to local partners improve activities designed to meet the vital needs of the affected population. Planning programmes that build human capacity through training and improve access to health care facilities protect the health of the displaced population and of the host communities.

*(Source: 'Health Project for the Internally Displaced Population in Colombia: Emergency Preparedness and Disaster Relief Coordination Program, PAHO, Jan. 2000)*

DM-12

World Health Organization
Department of Emergency and Humanitarian Action

# Presence and Surge Capacity for Public Health in Emergencies

Programme Brief, August 2001

Human survival and health are the cross-cutting objectives and the measures of success of all humanitarian endeavour. WHO's goal " **to reduce avoidable loss of life, burden of disease and disability in emergencies and post-crisis transitions**" is core to the humanitarian agenda.

WHO's Department of Emergency and Humanitarian Action (EHA) contributes to the Organization's goal by ensuring that at field, regional and HQ level **the Organization has the presence and operational capacity needed to strengthen coordinated Public Health management for optimal immediate impact, collective learning and health sector accountability** in the situations mentioned above.

Today, through its Representatives, Country Liaison Officers and Heads of Humanitarian Offices, WHO is **present** in 148 countries and territories worldwide. In addition, WHO sub-offices are becoming more frequent and expand the Organization's operational capacity in special situations: from Somalia to Afghanistan, from the Caucasus to Africa's Horn and Great Lakes regions, from Indonesia to Colombia, from Iraq to Angola. There is growing consensus across WHO that "wherever we feel that something is bound to happen", the Country office needs to be strengthened. In coordination between Country, Region and HQ, dedicated officers are appointed as"EHA focal points" at country level. The strategic objective is to support the Host Country's preparedness programme and ensure that whenever an emergency takes place, a public health specialist is there to provide the first, life-saving action and advice ( see *WHO's Core Corporate Commitments*). Furthermore, following the example of PAHO, some strategically-sited WHO offices are being given sub-regional functions for emergency preparedness and response, e.g. to support and monitor cross-border humanitarian operations and capacity building. Similar experiences are underway also in AFRO and are considered in WPRO. They are not yet institutionalised, but represent a positive trend that deserves supporting and replicating.

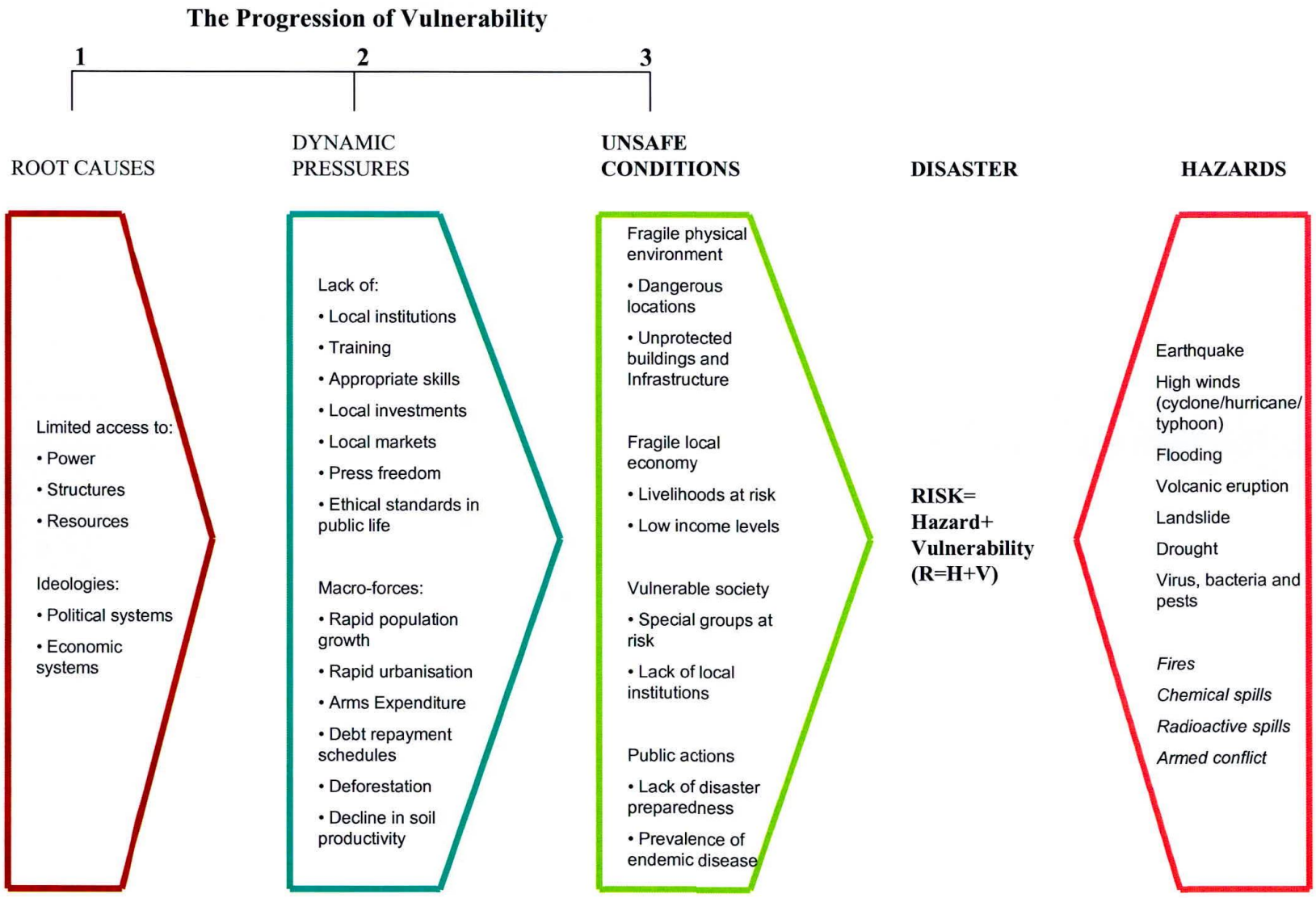
Whatever WHO's presence at field level, though, an emergency- by definition- calls for extra-ordinary measures and resources. Therefore, WHO needs to have **surge capacity** to ensure that its public health expertise is translated in concrete life-saving actions. The strategic objective is to provide prompt additional public health resources as needed, when and where needed. PAHO's experience is that much can be done by mobilising regional and sub-regional solidarity and expertise. AFRO is consolidating regional rapid response health teams and was quite successful in Mozambique's floods of 2000. However, especially for complex emergencies, external, international assistance remains critical. Donor countries, are increasingly demonstrating their capacities and goodwill in this area, e.g. in Kosovo and Mozambique. Thus, EHA is exploring the feasibility for WHO to enter arrangements with major donors, by which human and material resources would be made available to the Organization for deployment "at 24 hours notice", with procedures similar to those adopted for the WHO Emergency Revolving Fund. By appropriate induction briefing and technical monitoring, EHA would ensure that these additional resources are in line with WHO's corporate strategy, technical views and standard procedures. By coordinating a prompter and more focused health response in disasters, WHO would greatly contribute to improving the global humanitarian relief scene.
For more detail, see www.who.int/disasters or contact eha@who.int

## Getting your information out

- **Take public information seriously** You don't need to be at the media's beck and call all day to be media-friendly, but you do need to be accessible if you are going to get make the most of the inevitable media attention. Try and set a time for media queries each day, especially if the situation is changing fast. Be prepared to do one-on-one interviews with important media. If you have an information officer, or a staff member with good communication skills ad a strong ability to tract the situation as it progresses, consider giving them the authority to deal with media queries directly and to manage access to you.
- **Face to face: press briefings** Holding a daily (or even twice-daily) 15-30 minutes briefing - run by your spokesperson - either first thing in the morning or later in the afternoon is the most efficient way to update media en masse in fast moving situations. Face to face briefing is more efficient both for you and the media than written materials. Sometimes in emergencies, one organization will have responsibility for overall press briefing across the sectors. If so it's very important to be physically present, to contribute, and to field queries on health subjects. The aim is not only to have stories written directly about health issues, but to ensure that health is present in broader reporting of the crisis.
- **Face to face: press conferences** Hold a formal press conference when you have something specific to say - an important issue to raise, action to urge, an appeal, an impactful activity to announce - or bad news. Call the press conference immediately you hear important news - bad news does not improve with age. Try to have other partners/players there to add their comment.
- **On paper: situation updates** Situation updates should be brief paragraphs outlining what new information or issues have come to WHO that day (or later in a crisis, that week). Look for new information or a new angle, don't simply repeat. But also make sure you follow "running stories", for example, the number of cases in an outbreak, the movement of people, the progress of sample investigation. Be ready for requests for interviews or filming in the field situations, which are opportunities to add emphasis and detail.
- **On paper: press releases** Use press releases when you want to get a specific piece of information or an issue to media outside the immediate crisis area. Say clearly what your message is in the first paragraph - don't preamble. Then cover: who, what, where, when and, very importantly, why what you are announcing is important. Try to include a quote from the WR and, where appropriate, other partners such as the Ministry, NGOs or agencies. Fax or email the release to local and international media and news agencies, websites such as Relief Web and WHO's emergency and humanitarian action sites, and "interested parties" such as donors or NGOs.
- **On air: public service announcements** If you want to get public health messages across rapidly in an emergency, think sound. Radio is often the most accessible, sometimes the only method of communicating with scattered and scared populations.

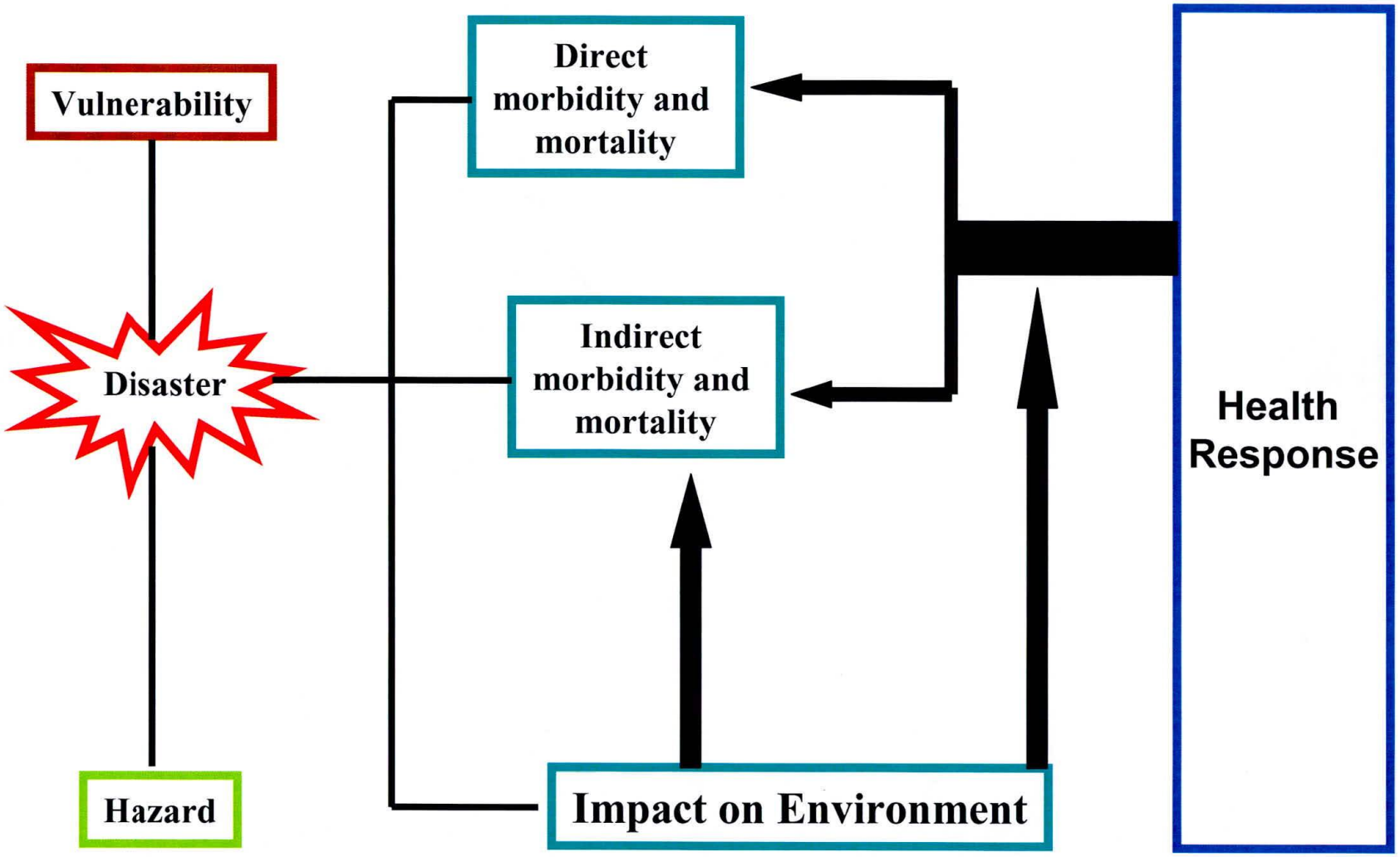
For more information please contact Melanie Zipperer, Communication and Media Relations Officer, Department of Emergency and Humanitarian Action, WHO, email: ZIPPERERM@WHO.INT, mobile tel. (+41) 79 477 1722;

# DISASTERS OCCUR WHEN HAZARDS MEET VULNERABILITY




Adapted from:Fig 2.1 'Pressures that result in disasters: the progression of vulnerability'
At Risk Natural Hazards, people's vulnerability, and disasters by Piers Blaikie, Terry Cannon, Ian Davis, and Ben Wisner

# DISASTERS AND HEALTH



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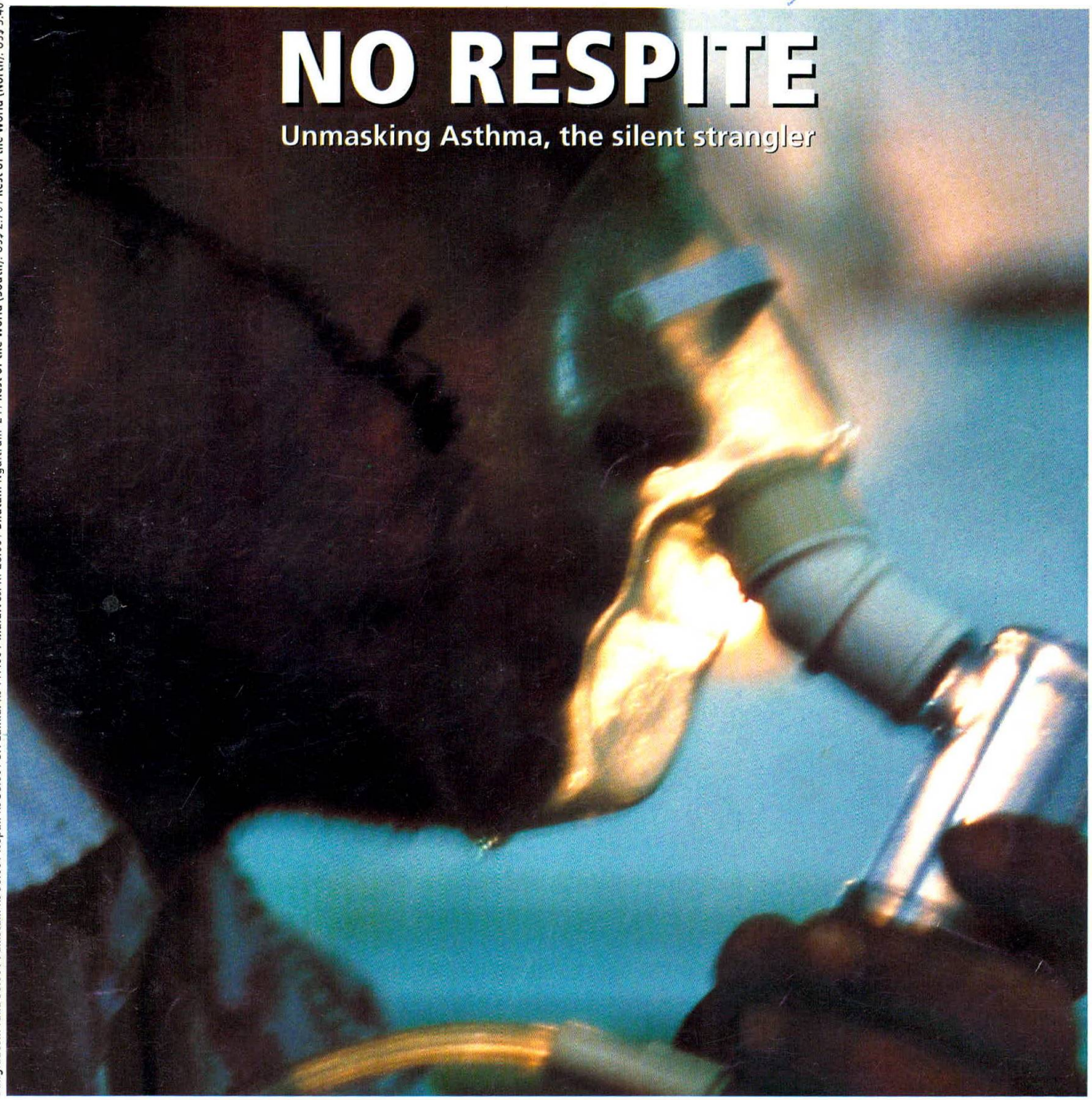


## NO RESPITE

Unmasking Asthma, the silent strangler

Water rises, voices drown in Tehri

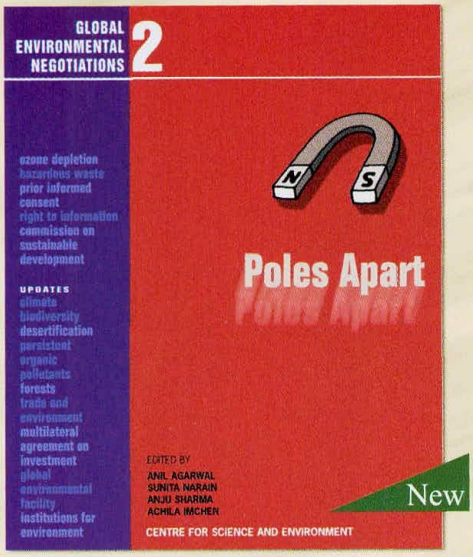
Fishing rights: Tawa sets the trend

In search of a corridor for elephants

In September 2002, a World Summit on Sustainable Development (WSSD) will take place in Johannesburg, South Africa

# HOW TO BE POLITICALLY CORRECT

## WHAT DOES SUSTAINABLE DEVELOPMENT MEAN ?

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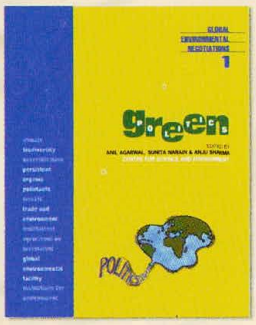


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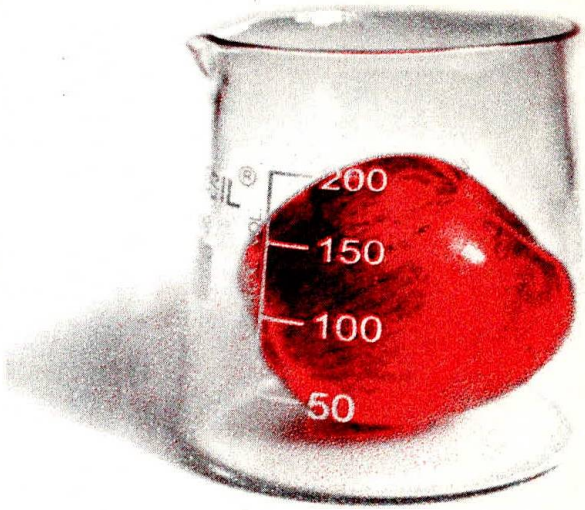
# An apple a day may not keep the doctor away




How fresh is a red apple? Don't trust your eyes. It is lined with harmful pesticide residue and heavy metals. And it is not only the apple. Most of our foodstuff and the water we drink are suspect materials for our health.

But we cannot complain or build up any meaningful and informed opinion against it. We are helpless as we lack scientific data.

Centre for Science and Environment, as part of its commitment towards a clean and safe society, has started a state of the art laboratory dedicated to detect deadly pesticide residue and heavy metals in our foodstuff, beverages, water and bloodstream. It also undertakes testing of water for a complete profile of pollutants, even for individuals. We encourage civil society organisations around the country who are into mass movements against pollution to come forward and use this facility to test any "suspect" material.

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For details, contact:
Dr N K Satija, Head, Pollution Monitoring Laboratory
satija@cseindia.org

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# GASPING MILLIONS

*"When you can't breathe, nothing else matters"*
— the American Lung Association

Asthma, it's the burden of modernity. It will strike 32 million people in India by 2010. The silent strangler has a propensity to waylay children, striking with stealth. At best, it can be controlled — it is yet incurable.

What triggers Asthma, what reins it in? And, is there hope tomorrow for the strafed millions? PRANAY G LAL pries behind the cloak of the killer, which garrottes nearly 500 victims every day and leaves innumerable more suffering a life of anticipated terror

LIKE A FISH out of water, she chokes and gasps. Writhes. She struggles to snatch a lungful of air, while watching television she suddenly hits a vacuum. She is asthmatic. She is just about anybody. One of the 150 million that are reminded the hard way that life in today's world is just a breath away from turning into a statistical entry in the death register.

But asthma doesn't discriminate, not between sexes, at least. She could just as well be a boy. The medical fraternity is sure though, asthma does prefer the affluent and the children of affluence, more so. It is the curse of modernity. A morbid attendant at the door to the new world, waiting to catch the entrant unawares. A murderer that chokes 180,000 people to death each year. And the lists of its victims only grow longer each year with humans increasingly embracing a lifestyle that is too cushioned to resist the onslaught of allergen.

Doctors try to fathom the method to the madness, predict a trend. But trends emerge as chaotic as the life of an asthmatic.

If you are not an asthma patient here's how you can experience the misery of one: take a deep breath. No, do not exhale. Not just now. Hold it for 20 seconds. Now exhale. But only for two seconds. Inhale again, holding it this time for 15 seconds. Repeat this for intervals by holding your breath for 10-15 seconds more. Never before did oxygen feel this precious. To slip from the precipice into an abyss, just about. To be pulled back, finding your feet grounded again, only to fall back once more. Repeatedly. Millions of people, often children, regularly endure this near death experience. Attacks occur suddenly, without any provocation. Today in India, about 15-20 million asthmatics daily live this encumbering reality. One out of 10 children in the country are asthmatic. In Delhi alone 700,000 people live under the spectre of asthma.

Asthma is more prevalent in Australia, the UK and New Zealand. In the US, asthma cases have shot up by 75 per cent between 1980 and 1994. The disease kills 5,000 US citizens each year. The rates of affliction are much lower in Asia — about

PREETI SINGH / CSE

eight per cent on an average, compared to the global average of 14 per cent. Across countries in Asia, and within each country, significant variations exist.

But experts are unanimous that in case of India the disease is one of the most underreported ones. In fact, nine out of 10 cases of asthma in children go undetected say some guesstimate. And while children may be the primary targets, asthma in adults too seems to be on the rise. The *British Medical Journal* reports on a Scotland-based study that showed asthma in adults to have doubled in the past two decades.

## Baffled by figures

And the rate of those inflicted with the debilitating disease increases by 12 per cent every decade. This is the world average and it is a conservative figure. Real figures, however, may never emerge. Diagnosing asthma is never easy.

A plethora of triggers bring the disease into play. Just as the number of those afflicted rises, so does the list of triggers. Environmental triggers like diesel, lifestyle-related ones like junk food consumption — the range is maddening and frustrating for the patient, the doctor and the researcher.

In India, data on asthmatics is not collected officially. The data bank created could help find patterns — trends that help focus medical and pharmacological research. So a comprehensive picture of the disease continues to elude experts. Elsewhere, there is a great wealth of research on asthma, but with little consensus. Some report that smoking, exposure to allergen, dust mite or cockroaches cause asthma. Others report that there is a genetic link. While one section of the research looks for reasons behind asthma's spread, the other tries to find cures and disease mitigating drugs.

An asthmatic, trying to figure out just what triggers the spasmodic dance of the devil inside, cannot wait for a medical breakthrough or a cure. The asthmatic learns to live with whatever drug regime is affordable, whatever provides some solace. This moment.

# Trigger happy

*Asthma is easily caused. Innumerous allergen, from pollen grains to dust mite, play havoc, exacerbating the disease. While experts are unable to reach a consensus, one thing's clear: modern lifestyle contributes to this disease*

ASTHMA affects people of all ages, runs in families and can be severely debilitating, even fatal. It picks on the vulnerable children. Recent research suggests that genetic, lifestyle, medical and environmental factors combine together, often inextricably, to cause asthma. This is undisputed. Researchers are now investigating other triggers and risk factors such as family size, exertion, housing, socioeconomic status and allergen in air and food that contribute to its onset and severity.

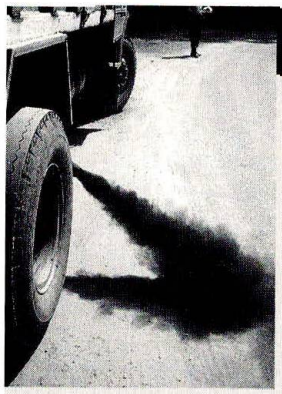
## Genetic causes

**ATOPY:** The propensity, usually genetic, for developing immunoglobin E (IgE) mediated responses to allergen is probably the strongest identifiable risk factor for asthma development. A review of clinical evidence by Adnan Custovic of Wythenshawe hospital in the UK in 1998 showed most asthma patients to be atopic — they are prone to producing abnormal amounts of IgE when exposed to allergen like domestic mite, animal proteins, pollen and fungi. Atopy occurs in 30-50 per cent of the population, but overall asthma prevalence is usually much lower. In other words, most asthmatics are atopic but only some with atopy will develop asthma. Yet, when expressed in the lower airways, atopy remains among the strongest predisposing factors for developing asthma. J K Suri, head of respiratory medicine at Safdarjung Hospital, Delhi, says, "While environmental factors aggravate asthma, they cannot be supported without a strong genetic base."

**ETHNICITY:** Asthma occurs among all races. Yet marked ethnic differences have been observed. Minority groups are not only asthma-prone, they also are more likely to die. African Americans are 2.5 times more likely to die of asthma than whites. Puerto Ricans have asthma rates 2-3 times more than whites while, paradoxically, Mexican Americans have rates significantly lower than whites, says Malcolm Blumenthal, a professor of medicine at the University of Minnesota-Twin Cities. Another study observed that in the group aged 5-34 years, asthma mortality rates were 0.5 per 100,000 in Chinese, 1.3 per 100,000 in Indians, and 2.5 per 100,000 in Malay subjects. Similar variations were seen for other age groups. In the 1960s, there was a rise in death rates in New Zealand, Australia and the UK, and a decade later a second epidemic of deaths was observed in New Zealand disproportionately affecting Maoris. Scientists suggest western lifestyle may partly explain such differences, but exact reasons remain unknown.

**AGE AND GENDER:** That children are becoming increasingly vulnerable to asthma is now confirmed. But the reasons are poorly understood. Childhood asthma is more prevalent in boys than in girls. However, this increased risk seems more related to narrower airways and increased airway tones in boys, which predispose them to enhanced airflow limitation.

**GROWTH OF THE CHILD:** Asthma evolution depends on the age of onset and possibly on the etiology of the disease. Disproportionate foetal growth (large head and small trunk), that is often associated with a birth weight of less than 2,500 gramme may carry an increased risk of developing asthma during childhood or adolescence. Poor nutrition in underweight babies may also impair basic immunological mechanisms. There is a correlation of early wheeze with reduced lung function before the development of symptoms suggesting that small lungs may be responsible for some infant wheezing that resolves with the child's growth. Asthma may disappear in 30-50 per cent of children at puberty, but often reappears in adult



## AIR ATTACK

**Asthma incidences can be reduced**

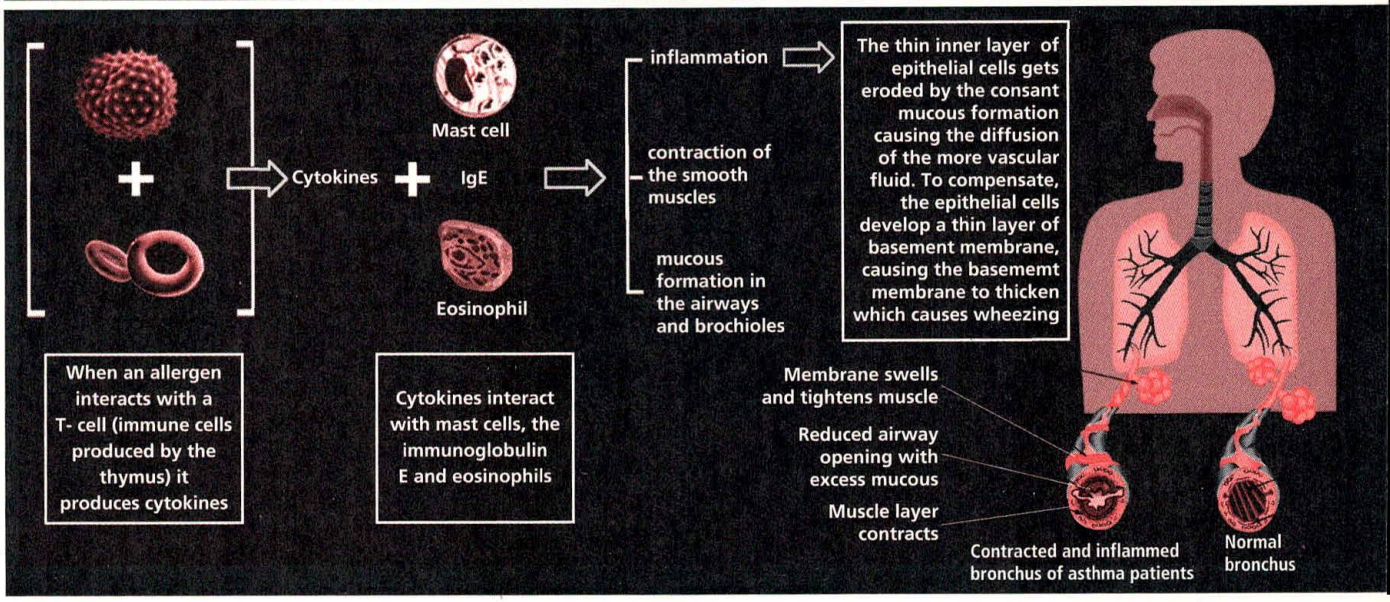
**Air Pollution aggravates asthma. Industrial smog (sulphur dioxide particulate complex) and photochemical smog (ozone and nitrogen oxides) are known to be triggers of mass asthma attacks. Yet the causal relationship is complex.**

**Asthmatics are the most sensitive group in a community, that is, they suffer the most at lower levels. Long-term exposure to even low concentrations of particulate matter in air results in increased rates of bronchitis and reduced lung function. Ozone reduces lung function in a continuum, that is, higher the concentration, longer the duration of exposure, greater the effect. Though scientific studies have found a wide range of sensitivity to sulphur dioxide among both healthy people and those with asthma, says World Health Organisation (WHO), even concentrations as low as one part per million (ppm) can trigger an attack. These studies also show that sulphur dioxide has continuous exposure-response relationships without any clear safe level, it points out.**

**Though research on asthma is yet to reach a consensus on the exact mechanism and the quantum of effect of these pollutants at different levels of concentration, most studies acknowledge that air pollution triggers violent asthma attacks in pre-sensitised atopic and normal individuals.**

**Although asthma prevalence is higher in industrialised countries, the direct role of air pollution has been questioned by some studies. While a study of two German cities showed that asthma and allergy were significantly more prevalent in the western city of Munich with its heavy automobile traffic, as compared to Leipzig in the east, which has heavy industrial pollution, a study by the Centers for Disease Control and Prevention (CDC) shows that lesser use of automobiles in Atlanta during the 1996 Summer Olympics led to improved air quality and a large decrease in childhood emergency room visits and hospitalisations for asthma.**

# THE ANATOMY OF AN ASTHMA ATTACK




life and up to two-thirds of children with asthma continue to suffer through puberty and adulthood.

## Lifestyle factors

**AFFLUENCE:** The prevalence of childhood asthma and atopy varies widely between countries. Alistair Stewart doing a study for the International Study on Asthma and Allergy in Childhood (ISAAC) studied the correlation between gross national product (GNP) and the symptoms of asthma and other allergies in children from across 56 countries. A moderately strong correlation was established between GNP per capita and the prevalence of asthma. This means the more the income per capita, the greater the prevalence of asthma.

High-income countries like the US, Canada, New Zealand, Australia and the UK have an asthma prevalence rate of between 20-30 per cent in these age groups. Many Latin American countries like Brazil, Costa Rica and Peru have an unusually high prevalence rate of around 20 per cent. Though India and China have a lower prevalence rate (between 4.2-6 per cent), the total number of asthmatics is very high. Also asthma cases are underreported and poorly diagnosed in India and China because of the stigma attached to the disease.

Writing in *Thorax*, a medical journal published from the UK, Adeola Olusola Faniran compared the prevalence of symptoms in Australian and Nigerian children and found that wheeze and persistent cough were less prevalent in Nigeria (10.2 per cent and 5.1 per cent respectively) than in Australia

## by controlling air pollution

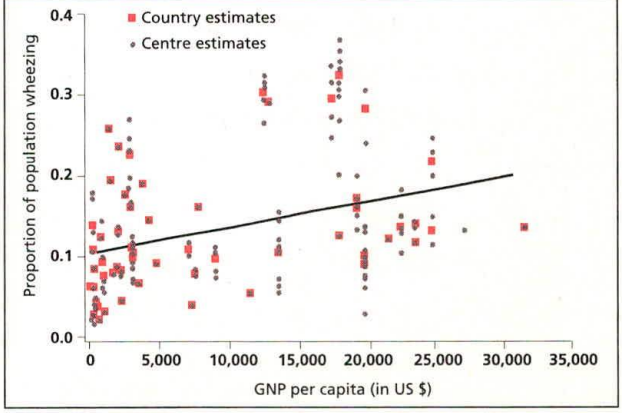
**A study done in 1986-92 in Barcelona, Helsinki, Paris and London during 1982-92 showed a significant increase in the number of the reported cases of asthma with the rise in the air pollutant levels. Cases for adult asthma increased with the increase in the nitrogen dioxide levels whereas the sulphur dioxide levels affected children.**

**Another study confirms that air pollution levels affect the children more than it does adults. The prevalence of asthma in schoolchildren has been increasing gradually in Taiwan. High levels of nitrogen dioxide, ozone, carbon monoxide, air-borne dust particles and total suspended particulate were significantly related to 8-29 per cent increase in the asthma risk. A World Bank study states that in Delhi, one out of 10 children aged 5-16 suffers from bronchial asthma, which is caused in part by air pollution.**

**Thus, even though there persists an uncertainty on whether air pollution causes asthma, there is a wide consensus that it aggravates the disease. Reason enough to operate on the precautionary principle and reduce levels of air pollutants and exposure to them.**

## Telling difference

**Asthma prevalence rates in high-income countries like the US and Canada are higher than in low-income countries such as India**




*source: Alistair W Stewart et al, The Relationship of per capita gross national product to the prevalence of symptoms of asthma and other atopic diseases in children (ISAAC), International Journal of Epidemiology 2001; No 30, p173-179*

(21.9 per cent and 9.6 per cent, respectively). Though there was no significant difference in the overall prevalence of atopy between the two countries (Australia 32.5 per cent, Nigeria 28.2 per cent), atopy was a strong risk for wheeze in both countries. Despite this, Australian children had a higher prevalence of asthma symptoms. This could be related to various environmental factors, allergen exposure or to different racial susceptibility, genetic predisposition and environmental factors.

But the story is not as simple as it sounds. Hospital records suggest that people of low socioeconomic status (SES) experience higher mortality and morbidity in comparison with people belonging to higher SES. A study done in London found the severity of asthma cases being more prevalent in the poorer sections. The poor seek treatment and admission only when there is a crisis. They rarely follow a planned treatment procedure and are under-users of primary healthcare facilities. The attendance rate in casualty departments by the poor during acute asthma attacks is four times more than other user groups. Evidently, while the poor may suffer lower incidence of asthma, when the disease does strike, it leaves them in a worse situation than the rich.

Another study shows how the prevalence of severe asthmatic crisis increases inversely with the declining SES of the patients. In Korea, mortality avoidable by medical intervention, defined as 'mortality wholly or substantially avoidable by adequate medical care' decreases with the growth in socioeconomic conditions and health services. These studies show that inequalities in health do exist. Are the poor more susceptible and more exposed to trigger agents? If so, is it possible to modify some of these determinants of disease severity? But how does this conform to the findings of the ISAAC study on the inverse correlation between income (GNP terms) and asthma prevalence? It is time to design our health policies based on epidemiological studies and demographic distribution.

**SMOKING:** There is now proof that while passive smoking causes increased incidence of wheezing illnesses in the first few years, it does not increase the risk of sensitisation to common aeroallergens, an important risk factor for asthma that onsets later. Surveys show that wheeze and asthmatic attacks are more prevalent in children whose parents smoke.

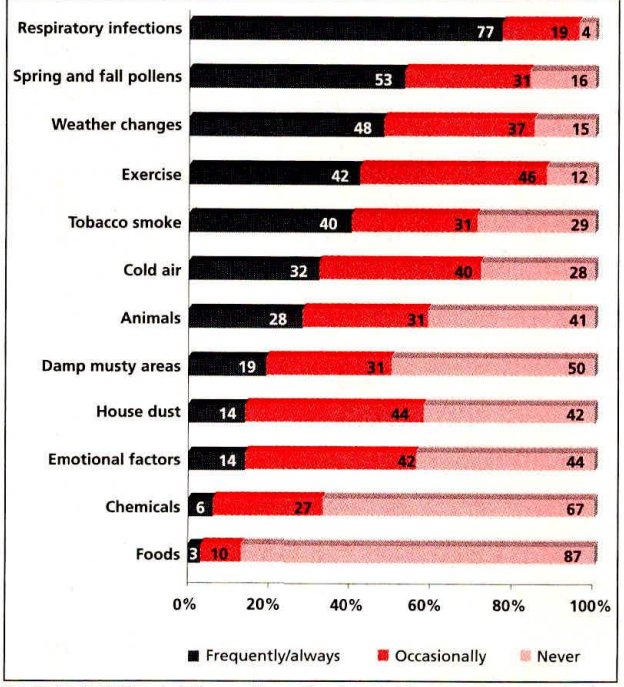
**DIET:** The role of dietary factors is under scrutiny, but no clear results have emerged. A recent paper in *Thorax* by Nariman Hijazi investigated dietary and other factors for asthma in Saudi Arabia where major lifestyle differences are found in different communities. It found that family history, atopy and eating fast food were significant risk factors for wheezy illness, as were the lowest intakes of milk and vegetables and of fibre, vitamin E, calcium, magnesium, sodium and potassium. Studies show that low intake of fish may weaken asthma resistance and evidence suggests that intake of omega-3, a fatty acid found in fish oil, may help keep the disease away.

It is also widely believed that food allergies are common asthma triggers, though evidence is rare. Some food and additives, including salicylates, food preservatives, monosodium glutamate and some food-colouring agents, cause asthma symptoms in some patients.

**OBESITY:** Obesity is associated with asthma symptoms regardless of ethnicity. The association is consistent with the basal metabolic rate because obese children are more advanced in their maturation than other children. There is some evidence that this association is stronger in girls than in boys.

## Risk index

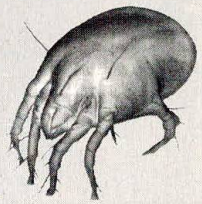
### What gives rise to asthma in children?




*Source: Scott T Weiss et al, The prevalence of environmental exposure to perceived asthma triggers in children with mild-to-moderate asthma. Data from the childhood asthma management program (CAMP), Journal of Allergy and Clinical Immunology, Vol 107, No 4, April, 2000*

## Mighty mite

### The dust mite too poses an exacerbate asthma



**It lives in your pillow and if you have asthma it could be your worst enemy. It is the dust mite.**

**The house dust mite are tiny (up to 0.3 mm) arthopods, which revel in the dust. Their numbers in a house depend not on cleanliness, but on the amount of moisture in the house. They eat the dust, which comes from our skin all the time. They leave droppings everywhere they go. Their droppings contain leftover enzymes, which the mite use to digest the skin dust. It is these enzymes that cause asthma and other allergic diseases.**

**In fact, house dust mite and their droppings are the most prominent cause of asthma worldwide. There is ample proof that minimising mite leads to a decrease in allergic symptoms. But, in practice it is proving to be almost prohibitively difficult for most people to beat this little pest.**

**One way found out of the vexing problem has been the new patented bedsheet which prevents the mite from breeding in the bed or the pillow or peircing through the thickly knit fabric of the sheet.**

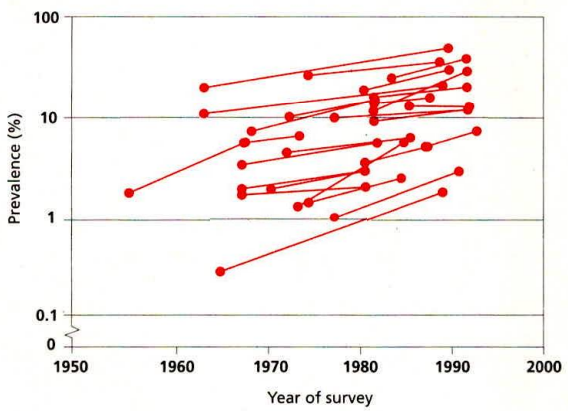
## Environmental triggers

**ALLERGIES:** The most important allergen are probably inhaled allergen, like mite, fur of animals, fungi and pollens. Allergen sensitise atopic persons by stimulating the development of specific T lymphocyte cell clones and the production of specific IgE antibodies. Once a person is sensitised (that is, has developed memory T lymphocytes and specific IgE), they are likely to develop allergic inflammation upon re-exposure to the same allergen.

The introduction of mite, the presence of large numbers of insects and cockroaches in tropical countries are some important episodes in the history of asthma. Climate is important because it is directly related to the amount of allergen present in the environment. For example, a damp and warm climate is favourable to mite and mould growth. Sensitisation to allergen by exposure to sources like house-dust mite, cats, dogs, cockroaches and smoke is strongly established, while other factors are less strongly correlated.

### Chaotic trends

**Every survey throws up different trends. But they are all in agreement: asthma is on the rise globally**




*Source: D Jarvis, P Burney, 1998, ABC of allergies — the epidemiology of allergic diseases, British Medical Journal; 316: 607-610*

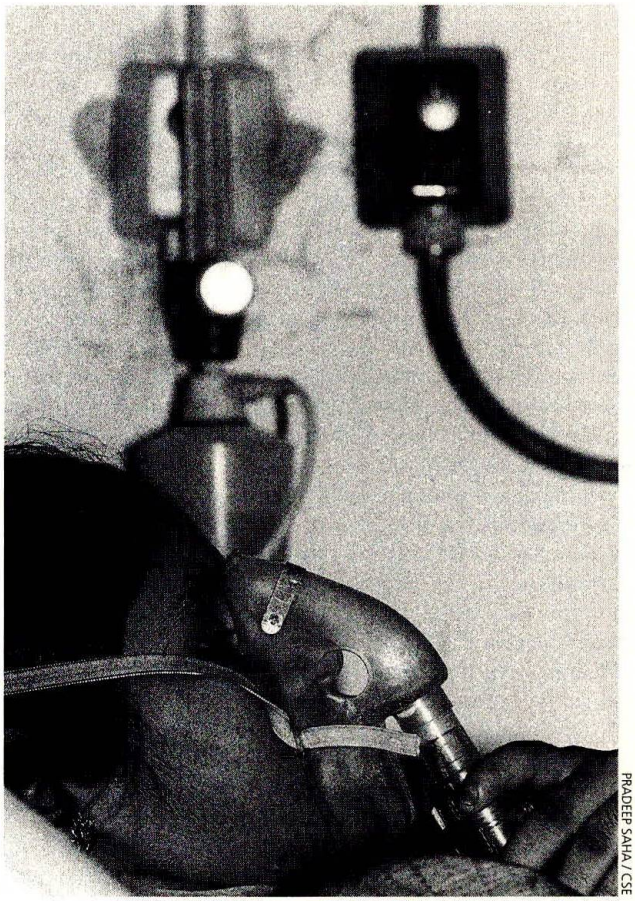
According to S K Kabra, an asthma specialist with the All India Institute of Medical Sciences in Delhi, in the general population of India, 60 per cent of the patients suffer from asthma due to viral infections and 40 per cent of the cases are due to allergen, pollens or seasonal variations.

**URBANISATION:** Universally, levels of asthma in urban communities seem to be higher than in rural ones. Yet, urbanisation involves so many changes in environment and lifestyle that a definitive explanation for this has so far been elusive. Urbanisation with accompanying pollution appears to be more directly related to increase in allergy. For example, in polluted Swedish and Chilean cities, asthma has increased drastically in the last two decades. In Japan, the increased allergy to *Cryptomeria japonica*, soft wood pine, has been attributed to sensitisation to urban diesel exhausts.

The trigger happy asthma needs just as many treatments to catch it before it hits hard and to limit its effects. It is, one must remember, controllable, even if not completely comprehensible.

# Breathing easy

***A hundred medicines, a dozen therapies but no cure, that is the story of asthma treatment world wide. Complementary medicine fill the vacuum***



PRADEEP SAHA / CSE

WITH increasing patients and many of them in industrialised nations the market for asthma drugs is growing rapidly. It is the eighth largest selling drug market and possibly the most profitable venture for pharmaceutical companies, at par with profits made from cancer and heart diseases related drugs.

In the absence of evidence of the global growth of asthma, sales of drug and medicines to treat asthma are a good indicator of how fast the disease is actually growing. According to the US-based Asthma and Allergy Foundation, USA, spends US $2 billion annually seeking asthma and allergy relief and globally the market is estimated to be at US $4.8 billion. Singulair, Merck's once-a-day leukotriene-antagonist medicine, alone grosses worldwide sales worth US $860 million.

But compare this to the budget spent on research and development of drugs for asthma and one comes to know why the disease is not finding any adequate response in the thousands of prescriptions being handed out daily. The Pharmaceutical Research and Manufacturers of America (PhRMA) estimates the total budget of asthma research is only US $1 billion of the total US $80 billion industry. The revenues from asthma drugs comprise about a healthy nine per cent of the total sales in

western markets according the World Pharmaceutical Outlook 2000. Just 15 years ago, in 1985, asthma drugs commanded only 1.5 per cent of the total global revenue. Against this backdrop, one can evaluate the drugs, therapies and treatments present today in the market for asthmatics.

## Medication for asthma

Asthma is not yet curable and neither does any convincing evidence exist yet to prove that it could be prevented.

It can, however, be treated and controlled. Good care and a regimen of some expensive drugs can convert asthma from a major handicap to a minor nuisance.

Treatment for asthma is based on the severity of the problem faced by the particular patient. Three main types of treatments are usually recommended. The first set of medicinal treatments is called bronchodilators. These make the muscles around the airways relax. As this happens, air tubes open up, making it easier for the patient to breathe. The other group of medicines reduce swelling and irritation in the airways and are collectively called anti-inflammatory drugs. Corticosteroids are an example of such anti-inflammatory steroids and are used very frequently. Anti-inflammatory medicines help to control the inflammation of airways and prevent the onset of asthma attacks. They work to reduce the swelling in air tubes and keep them open for passage of air. Consequently they also decrease the mucus.

Inhaled corticosteroids, which help relax the muscles around the airways, are the most favoured these days. They dominate the asthma market, accounting for one-third of major-market sales of asthma medication. They are the most effective long-term preventive medications since a greater percentage of the dose is able to target the inflamed lungs. Doctors also commonly prescribe other anti-inflammatory medicines like cromolyn sodium and nedocromil.

Interestingly, sensitising to low doses of trigger antigens can also be helpful in preventing asthma attacks. But this treatment is rarely done in India as it is too expensive and requires a long treatment time with no assured relief. The risk also exists of the patient suffering adverse reactions to the allergen.

## Four steps to well being

Based upon a set of symptoms, a stepwise approach is advised for deciding the medication regime. A predetermined set of symptoms is used to grade the severity of asthma attack. The number of drugs used, type of drugs, dosage levels and the frequency of medication, all depend upon where the patient stands on these four 'steps' (see box: *Asthma control regime*).

As in other medicines, the drugs are sold under brand names and not generic names. They come in different forms, including sprays, pills, powders, liquids and shots. When corticosteroids are inhaled as in a spray, the risk of serious side effects is minimised if not done away with completely. The chance of suffering side effects increases when these medicines are taken in the form of pills or as a liquid and that too over a long period. In case of pills or liquids the patient needs to go for regular check-ups by a doctor to make sure that the medicine works the best way. The medicines ease the asthmatic condition but demand that a lot of attention be paid to the usage and after care.

Although most medications aim to improve the lung function when administered regularly, they differ in their mechanisms of action, in their offset of effect and how they actually resolve inflammation. On breaking the performance of medications into subcategories of response, differences can be observed.

There does exist another kind of treatment that may be helpful if asthma attacks are triggered by allergies. This treatment is called hyposensitisation therapy or allergy shots. In India however, Kabra says, hyposensitisation therapy is practised very rarely as patients are rarely subjected to allergy tests. Quite often, patients through their own experiences are able to identify the allergen.

## Advances in medicine

A host of new medicines are also under development. Some of them seek to better the node of delivery, while others seek to optimise the chemical balances. Of all the therapies and medicines under development, omalizumab, an anti-immunoglobulin E (IgE) monoclonal antibody from Genentech/Novartis, holds the greatest promise, believe experts. The medicine is currently awaiting marketing

### Asthma control regime

#### Step 1: Symptoms occuring less than once a week

**Clinical features before treatment**

- Occurs less than once a week
- Mild symptoms
- Asthma symptoms during night
- Normal lung function between attacks

**Daily medication required to maintain control**

- Medicines to be taken as needed, orally
- Intensity of treatment depends on severity of attacks

#### Step 2: Mildly persistent symptoms

**Clinical features before treatment**

- Symptoms more than once a week but not more than once a day
- Attack may affect activity and sleep
- Asthma symptoms during night more than twice a month

**Daily medication required to maintain control**

- Daily medications to control symptoms and an anti-inflammatory along with bronchodilator for night time symptoms

#### Step 3: Moderately persistent symptoms

**Clinical features before treatment**

- Daily symptoms
- Attacks affect activity and sleep
- Night time asthma symptoms more than once a week
- Need to use inhaled medicines daily

**Daily medication required to maintain control**

- Daily medications for control and inhaled corticosteroid and bronchodilator especially for night time symptoms

#### Step 4: Severely persistent symptoms

**Clinical features before treatment**

- Continuous symptoms
- Frequent attacks and night time symptoms
- Physical activities limited by asthma symptoms

**Daily medication required to maintain control**

- Multiple daily control medications
- High doses of inhaled and oral corticosteroid along with bronchodilator

Note: The presence of one of the features of severity is sufficient to place a patient in that category.
*Source: Anon 2001, Asthma in America, asthmainamerica/slides/slide9.htm, December 4, 2001*

# The cost of asthma

**Best treatment is reserved only for the rich. The poor have to make do with ineffective substitutes**

**Under a global strategy for asthma management and prevention, the World Health Organisation has prescribed international guidelines. These guidelines recommend the regular use of prophylactic inhaled medication along with inhaled bronchodilators. But do asthma patients in poor countries receive proper treatment?**

**A survey conducted in 24 African and Asian countries found that the treatment prescribed to most of the patients in these countries fell far short of international guidelines. Easy availability of oral drugs that are also cheap (98 per cent of the centres had oral medicines) forced many doctors to prescribe oral therapy rather than the recommend inhaled therapy. The cost of the beclomethasone 50mg inhaler was 20 per cent of average local monthly income of many of these poor people in these countries.**

**In comparison, the cost of oral drugs (90 salbutamol 4 mg tablets) was only 3.8 per cent of the average local monthly income. A survey of general practitioners in Punjab revealed overuse of ephedrine and an under-use of the inhaled drugs because steroids are cheaper and provide almost immediate relief.**

**The challenge of fighting asthma remains. It is time the pharmaceutical industry makes effective inhaled medication available at prices that are affordable.**

approval. Dr Reddy's Laboratories' zafirlukast, a non-steroidal leukotriene modifier launched recently in India, too holds some potential. Leukotrienes are pro-inflammatory substances released during pathogenesis of asthma resulting in bronchoconstriction, oedema and inflammation. By selectively and competitively blocking leukotriene receptors, zafirlukast helps in effectively controlling a range of asthma symptoms and improves lung function. Available in oral pill form, just two doses a day of the drug could provide 24-hour protection from asthma attacks, claims the company. It remains to be seen how effective this new oral dosage treatment will be, given the physician's existing preference for inhalers to treat chronic patients.

Industry observers believe that the long-acting beta2 agonist-corticosteroid combination agents (which ease muscles around the airways) will become the most popular choice, replacing the single-agent inhaled corticosteroids and long-acting beta2 agonists. Both combination agents offer more convenient treatment regimens.

Therapeutically speaking, managing the disease has improved enormously over the past 20 years due to advances in both drugs and in the way these drugs are delivered. Pharmacological treatment for asthma relies heavily on ß-agonists and corticosteroids. The development of both classes of drug combined with a general improvement in management means that most patients with mild or moderate asthma can have a relatively symptom-free life. Nasal sprays that treat allergies have been improving. Older versions of the nose sprays frequently caused allergic reactions because they were essentially allergen in a water solution. Using a spray, patients would endure allergy symptoms until their bodies built up a tolerance to the allergen at hand. But researchers have learned that giving patients a spray of cromolyn sodium first can stifle a nasal spray's allergy-inducing response, while still providing protection against the allergen.

Other areas of developments involve the hunt for novel allergy targets. Some also see room for improvement in existing therapies. Innovating upon the allergy-shot method, a hi-tech US-based lab recently cloned the genes for allergen contained in cat dander and ragweed pollen. With genes in hand, they isolated the most potent portions of the allergen and then used just those portions to create refined allergy shots. In theory, these shots will deliver more therapeutic punch-over the course of just a few weeks and with fewer side effects.

Many experts believe that for a complex disease like asthma such an approach would work only for a few allergen.

While the researchers practicing allopathic medicine experiment with a handful of chemicals, trying to develop the best possible mix for a drug that will be more effective and have less or no side reactions, asthmatics have survived the agony of a million gasps by trusting other schools of medicine. These complementary and alternative medicine systems work out to be cheaper and more accessible, especially in India's case.

## Alternative medicine

Complementary and alternative medicine (CAM) systems may not be a part of the mainstream and conventional therapy but their popularity has only increased over time. Homeopathy, yoga, herbal medicine and nutritional therapies — all are finding an increasing number of asthma patients converting to the

## Future stock

**Asthma drugs still in the pipeline**

| Generic name | Company | Age group targeted |
|---|---|---|
| Xopenex | Sepracor | 4-11 years |
| Xolair | Tanox biosystems | 6 years and older |
| Flovent | Glaxo SmithKline | 4-11 years |
| Azmacort | Aventis | Not known |
| Ventolin | Glaxo SmithKline | 4-11 years |
| Seretide | Glaxo SmithKline | Paediatric patients |
| Advair | Glaxo SmithKline | Not known |
| Asmanex | Schering-Plough | 2-12 years |
| Aerobid | Forest laboratories | 6 years and older |
| Xopenex | Sepracor | Newborn – 6 years |
| Pediavent | Ascent pediatrics | 2 years and older |
| Foradil | Novartis | 5 years and older |
| Asmanex twisthaler | Schering-plough | 4-12 years |
| Oxsodrol recombinant human superoxide dismutase | Bio-technology general | Premature infants |
| Ciclesonide | Aventis | Not known |

*Source: Pharmaceutical Research and Manufacturers of America (PhRMA) website : www.phrma.org\asthma\asthma-cures.htm (as of Dec 23, 2001)*

## Faith fry

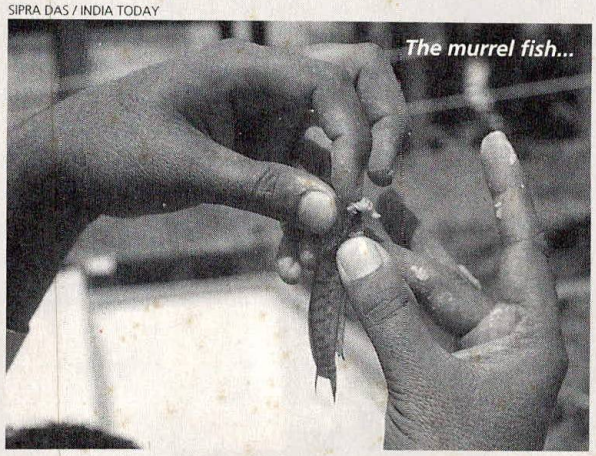
### A family in Hyderabad uses a unique therapy to treat thousands of patients

**Patients from across the country come to Hyderabad for an unusual therapy using a live fish every year in the summer on the *Mrigashirakarthi* day. The other three doses are given on the following three *nakshatras* (constellation moons) in the next 45 days. About 156 years ago, it is believed that a holy man blessed a well in a place called Doodhbowli in Hyderabad. The water of this well was used to make the mixture and passed on as a secret to one Veerrana Gowd. It has been passed down three generations to the current guardian, Shanker Gowd.**

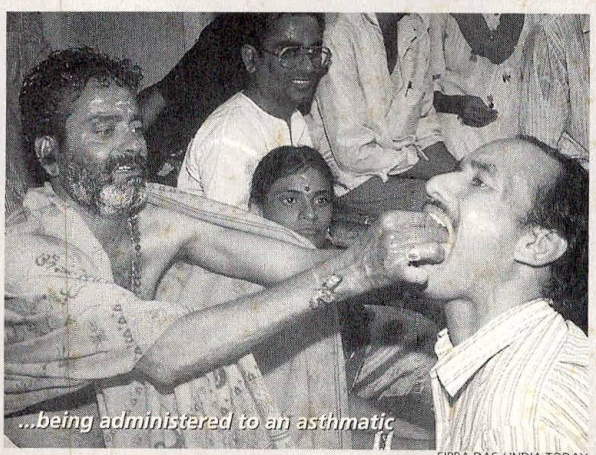
**A secret herbal recipe is put into the mouth of a 2-2.5 inch river fish called murrel (*Channa spp*). The fish delivers the medicine to the congested parts and in the process of passing down the throat, its slithering tail and fins clear the throat of phlegm. In case of vegetarians, banana could be used as the carrier for the medicine. The patients are told to follow a strict diet. The family provides the therapy free of cost.**

**Last year a record 800,000 people gathered at the exhibition grounds in Hyderabad for the treatment. "Till now, there haven't been any cases of side-effects," claims the Gowd family. So every year patients suffering with this disease come with the hope of getting cured forever, whether they do is also a secret.**

SIPRA DAS / INDIA TODAY



*The murrel fish...*



*...being administered to an asthmatic*

SIPRA DAS / INDIA TODAY

fold, looking for long-term and cheaper solutions.

And there are innumerable such options for the suffering to explore. Take for instance the ayurvedic herb, *Coleus forskholii,* which has a bronchodilating effect or the Chinese wonder herb *Ginkgo biloba* and *Tylophora asthmatica,* which improve pulmonary function.

While allopathic practitioners continue to doubt the efficacy of herbal drugs, two drugs have already been launched in the previous year —*Resipicare* (developed by Bafco) and *Asmon* (developed by the Indian Institute of Chemical Biology, Kolkata). Both manufacturers claim that their medicines effectively control asthma without any side effects. Doctors assert that herbal drugs cannot replace steroids and at best can be used along with an allopathic drug.

While these doubts may persist, a comparative study of CAM approaches done by George Lewith in *Thorax* finds that yoga breathing exercises — *pranayama* in a particular modification (called the Pink City lung exercise) is an effective therapy.

"Homeopathy too helps in improving the immunity of the patient," contends Chanda Shah, a practising homeopath in Mumbai and an asthma patient herself. She, however, recommends the usage of injections or a nebuliser in case of severe asthma attack.

### Awareness, the ultimate tool

But the most important weapon in the fight against asthma, believe doctors, is education. "Education should be our top priority" says S K Chhabra. "Asthma guidelines are given to general physicians abroad by associations like the British Thoracic Society or global protocols like the World Health Organisation. These should be observed here too and taught in the medical curriculum. This would go a long way in the correct diagnosis of the disease."

And it is not only about educating the asthmatics but about the doctors and medical researchers also learning more about the disease. Government agencies and research institutions in India need to wake up. The US government has specialised agencies like the National Allergy and Infectious Diseases, which specialises in research and creating awareness in public. Even the Environment Protection Agency educates about allergen like pollution due critical periods. Australia and New Zealand have special helplines and warning centres during the 'allergy seasons'. The least that the Indian government can do is enforce protocols like asthma management and create a platform for educating patients. This is true for the entire world also. Building a global research protocol on the epidemiology of the disease remains an imperative that is yet not paid attention to.

Meanwhile, scientists continue to seek a cure, attacking asthma from new directions, using a variety of disciplines — genetics, physiology, cell biology, epidemiology and immunology — to converge on the problem. That's a big change from years ago, when only allergists and lung experts studied the disease. The real challenge lies in comprehending the confounding number of triggers that push the millions of asthmatics into a paroxysm of gasps. It seems that there is no silver bullet despite so many triggers. Till one is found the sufferer will need to wait, with bated breath. ■

*With inputs from Sarita, D B Manisha, Chandrachur Ghosh, Apurva Narain, Jennifer O'Riley, Rachita Jha (in Delhi) and Pujita Krishna (in Hyderabad)*

DM-12

World Health Organization
Cluster of Sustainable Development and Healthy Environments
Department of Emergency and Humanitarian Action

**CRITERIA FOR WHO's INTERVENTION IN EMERGENCIES**

WHO intervenes to ensure integrated response to public health concerns in three typical emergency situations:

a) *Emergencies where humanitarian concerns affect all areas*. These are situations usually managed through the Inter-Agency Standing Committee with the support of the UN Office for the Coordination of Humanitarian Affairs (OCHA) and are covered by the UN consolidated appeals for complete emergencies (CAP). The UN appeals for natural disasters follow a similar pattern inter-agency consultations, but is the affected Government which has to launch its appeal for international assistance (which can then receive, if needed, coordination support from the UN).

b) *Health emergencies with an international dimension* (e.g. Rift Valley fever in Yemen) where WHO leads or co-leads the intervention and uses the IASC mechanism to address the health hazards.

c) *Situations where the health security of the affected populations or humanitarian workers is at stake.* Various areas of collaboration with OCHA are developed in these cases (e.g., recently, on depleted uranium).

To clarify when the UN declares emergencies and on the role of the IASC, here are relevant excerpts from the UN resolution 46/182:

"An Inter-Agency Standing Committee serviced by a strengthened Office of the United Nations Disaster Relief Coordinator [to day OCHA] should be established under the chairmanship of the high-level official with the participation of all operational organizations and with a standing invitation to the International Committee of the Red Cross, the League of Red Cross and Red Crescent Societies, and the International Organization for Migration. Relevant non-governmental organizations can be invited to participate on an ad hoc basis. The Committee should meet as soon as possible in response to emergencies".

… and from the Consolidated Appeal Process Guidelines endorsed by the IASC on 13 April 1994:

"The use of the CAP is principally to meet the demands of 'major' as well as 'complex emergencies'. Both major and complex emergencies are generally acknowledged to be those which exceed the mandate and/or capacity of any agency and are deemed to

require a system-wide approach. The determination of a complex or major Emergency will be made by the Inter-Agency Standing Committee (IASC), led by the Emergency Relief Coordinator. It is assumed that, as is the case for most international responses to disasters and emergencies, the initial request for assistance of a complex or major emergency will come from the Government of the affected country".

DM-12

World Health Organization
Cluster of Sustainable Development and Healthy Environments
Department of Emergency and Humanitarian Action

*July 2002*

# WHO RESPONSIBILITIES IN EMERGENCIES

*Human survival and health are the cross-cutting objectives and the measures of success of all humanitarian endeavour. Therefore, WHO's goal is "'to reduce avoidable loss of life, burden of disease and disability in emergencies and post-crisis transitions".*

*This is achieved by ensuring presence and operational capacity in the field to strengthen coordinated public health management for optimal immediate impact, collective learning and health sector accountability.*

- ✓ Identifying priority health and nutrition-related issues and ensuring that these are properly addressed in an integrated primary health care approach that preserves and strengthens local health system.

- ✓ Strengthening health and nutrition surveillance systems to enable monitoring of any changes, early warning of deterioration, and immediate life-saving action through outbreak response and technically sound nutrition interventions.

- ✓ Ensuring control of preventable ill health particularly communicable and vaccine-preventable diseases.

- ✓ Ensuring that risks related to the environment are recognized and properly managed.

- ✓ Ensuring access to basic, good quality, preventive and curative care including essential drugs and vaccines for all, with special focus on the especially vulnerable - the elderly, the very young, pregnant women, the disabled and the chronically ill.

- ✓ Ensuring that Humanitarian Health Assistance is in line with international standards and local priorities and does not compromise future health development.

- ✓ Advocating and negotiating for secure humanitarian access, and neutrality and protection of health workers, and the operation of services and structures as integral parts of public health provision.

- ✓ Ensuring that the lessons learnt in a crisis are used to improve health sector preparedness for future crises and disaster reduction.

- ✓ Defining an integrated health policy for preparedness, emergency response and post-conflict, for a coherent health sector development resilient to emergencies, to link relief efforts with national capacities and initiate future health system reform.

DM-12.

**Economic and Social Council**
**Humanitarian Affairs Segment**

**New York, 15-17 July 2002**

# Statement of the World Health Organization

*WHO will continue to be active in conflicts and crises, taking exceptional action to sustain health systems, to ensure continued delivery of health services and to protect the health of the population*[1].

The past year may go down in most people's memory as the "Year of September 11". New players and new concerns entered the humanitarian arena. This offers opportunities but adds in complexity to our work. It brings new responsibilities to the international community.

More complex emergencies turned chronic; twelve months ago we were responding to the unacceptable levels of mortality prevailing in the Democratic Republic of Congo[2]. We saw the conflict subside in Sierra Leone but engender a spill-over in Guinée; and now tensions flare-up again in Liberia. The poorest and most disease-ridden communities continue to need, and often fail to receive, substantial relief and, while polio is being eradicated, people continue to die of measles, pneumonia, diarrhea and malaria. The cessation of hostilities in Angola shows us the magnitude of the humanitarian needs of the newly accessible populations.

The escalation of violence in the West Bank brings forward pressing needs for humanitarian relief. It runs in parallel with the ambitious challenge of assisting Afghanistan on the way to national recovery while responding to the Afghan people's persisting, large needs for survival and dignity in the face of man-made and natural hazards.

Poverty continues as a major factor of vulnerability. As more people live in vulnerable areas, hazardous materials and rapid urbanization contribute to tragedies such as the series of explosions in Nigeria, the landslide in the garbage dump in Manila and the recent railway disaster in Tanzania. Well-known seasonal hazards return: floods are today's news in India and China like almost every year. Food shortages are re-occurring in Southern Africa : they interact with structural poverty, political instability and high prevalence of HIV/AIDS in a new humanitarian crisis that threatens at least 60 Million people with an estimated excess daily mortality of 8,000.

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[1] Gro H.Brundtlan d, Pre-WHA Meeting of Commonwealth Health Ministers, Geneva, 12 May, 2002
[2] International Rescue Committee. *Mortality in Eastern Republic of Congo*. New York, 8 May 2001

The fear inspired by bacteriological weapons calls the biomedical sciences and WHO on the frontline of preparedness and response. However, all crises, whether man-made or natural, are public health affairs, and the health sector is always on the frontline. Therefore, humanitarian and emergency action is central to WHO mandate, especially at country level, where each year one Member State out of five faces a major crisis. In Dr Brundtland's words, *we know from experience of responding to emergencies that prompt attention to health issues - through the provision of effective interventions - saves many lives."*[3]

Emergencies are about people's survival and demand that we take exceptional action. For too many people, today, continuing to exist in spite of drought, floods or war is a daily challenge, and health needs are a major part of it. Factors of vulnerability and risk are more complex than lack of food, shelter or protection: people die of preventable causes: measles, malaria, diarrhoeas, tuberculosis, maternal deaths. 65% of epidemics occur in complex emergencies, that also see the highest risk for HIV/AIDS, the highest rates of child and maternal mortality by preventable causes, the greatest burden of disabilities, the greatest challenges to the control of malaria and TB. Survival is the priority.

Ill-health is a major threat to survival and security. A prompt response is a political imperative, of which public health is an essential component. Timely health intelligence is a critical resource. Member countries, agencies and donors expect WHO, as UN technical agency, to be the leader in evidence-based coordination of the international health preparedness and response. Furthermore, the developing countries rightly expect that WHO work for humanitarian action contributes to the recovery and further development of local and national capacities in the health sector.

WHO is up to this challenge. Dr Brundtland clearly stated how emergency and humanitarian action are central to WHO global functions. She went further, stressing the need to protect health systems, to ensure access to the basic necessities for life even when there are hostilities and to resist the modern military trend to target the vital infrastructure of whole societies[4]. Emergencies or "exceptional situations" cannot be an excuse to accept the unacceptable: they just make it imperative that exceptional public health action is taken to ensure continued delivery of services and protect the population.

There are critical public health measures that are essential to save lives. The most reliable indicators of emergency needs are health indicators, and human survival is the ultimate measure of success or failure of humanitarian operations. WHO identifies those life-saving practices, adjust them to the epidemiological and operational context and ensures that they are applied in a coordinated effort by all humanitarian partners.

WHO has defined a set of "core commitments" in emergency for which it can be held to account. This represents a priority list of what the health partners must ensure for the survival of people in a crisis and, therefore, a model for preparedness plans. Around these priorities, WHO promotes institutional capacities and linkages in member states and partner agencies.

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[3] Gro Harlem Brundtland, Speech from *CAP 2002: Reaching the Vulnerable*, 27 November 2001.
[4] Gro Harlem Brundtland, statement at World Health Assembly, Geneva May 2002.

Coordination is essential even if difficult, and there is great demand for quality standards and accountability. WHO is ready to offer these for all. Sound and affordable interventions are known for most risks. Translating knowledge into practice is difficult, though, when interventions are mainly based on the values of the providers. Effective action demands needs analysis, inter-sectoral understanding, an articulated view of all factors of risk and of the synergies that exist between the different humanitarian inputs[5].

## A life-saving package from DRC

Mid-2001, a joint UNICEF/WHO mission travelled across the Democratic Republic of Congo to assess the health crisis. Following this, the two agencies brought together in a technical meeting health officials from four rebel-controlled areas and from Kinshasa.

The meeting reached consensus around a *minimum package of health services*, flexible enough to be applied both in acute and chronic emergencies. Even in DRC, life-saving activities can realistically be implemented at community and at health unit levels against seven major killers: malaria, measles, diarrhoeas, acute respiratory infections, malnutrition, maternal risk and HIV/AIDS.

For this life-saving package to be implemented effectively, security, safe water, shelter, sanitation and appropriate general food rations are needed, together with immunizations, vitamin A and curative health care. These essential public health goods, in turn, require cross-cutting support: epidemiological and nutritional surveillance, functioning local health systems, coordination of all partners, e.g. for the right treatment against malaria, but also for water and food to be in place, and as close to the needs as possible. This, in turn, requires logistics and, of course, resources, that need to be mobilised, while access and security have to be negotiated.

All this starts by the rapid assessment: of the needs that must be addressed, of what is already in place, of how much else is required and of the constraints that must be overcome.

### WHO responsibilities

- ✓ Identifying priority health and nutrition-related issues and ensuring that these are properly addressed in an integrated primary health care approach that preserves and strengthens local health system.
- ✓ Strengthening health and nutrition surveillance systems to enable monitoring changes, early warning of deterioration, and immediate life-saving action through outbreak response and technically sound nutrition interventions.
- ✓ Ensuring control of preventable ill health particularly communicable and vaccine-preventable diseases.
- ✓ Ensuring that risks related to the environment are recognised and properly managed.
- ✓ Ensuring good quality and access to basic preventive and curative care including essential drugs and vaccines for all, with special focus on the especially vulnerable - the elderly, the very young, pregnant women, the disabled and the chronically ill.
- ✓ Ensuring that Humanitarian Health Assistance is in line with international standards and local priorities and does not compromise future health development.
- ✓ Advocating and negotiating for secure humanitarian access, and neutrality and protection of health workers, services and structures as integral parts of public health promotion.
- ✓ Ensuring that the lessons learnt in a crisis are used to improve health sector preparedness for future crises and disaster reduction.
- ✓ Defining an integrated health policy for preparedness, emergency response and post-conflict, for a coherent health sector development resilient to emergencies, to link relief efforts with national capacities and initiate future health system reform.

System-wide accountability is hinged on the Humanitarian Coordinators and at country level WHO contributes through its commitments to public health. We still have much work to do in this respect. Accountability is also predictability and long-term commitment. WHO agrees that the approach to humanitarian needs must be medium to long-term in its perspective. At no time this principle becomes so valid as in the transition from relief to recovery, when crises run the highest risk of turning chronic.

[5] *...In the recent response to drought in the Horn of Africa, lack of funding to improve sanitation, water supply, health and the agricultural sector reduced the effectiveness of all relief programmes...'* WFP. Annual report of the Executive Director: 2001. Rome, May 2002

But prevention remains better than cure: greater resources need to be put into longer term programmes that promote sustainable healthy livelihoods, and not only mere survival. In the past months, the reception that decision-makers and the public awarded to WHO *Report on Macroeconomics and Health* confirmed that the real health needs of the people need more attention. The Report carries explicit benchmarks for financial investment in the health sector, below which people cannot be expected to have enough health to contribute to economic prosperity. These benchmarks provided useful background at the Donors' Conference on Afghanistan in Tokyo.

Public health is also evidence-based political action for equitable and effective allocation of resources, and WHO has a responsibility in advocating for public health in all domains. Thus, unfortunately, WHO must once again bring to the attention of the Council the fact that the Health section of the UN Consolidated Appeals remains under-funded. Humanitarian accountability means also that all actors are given the resources to perform at their best according to their mandate.

WHO work in the area of Emergency Preparedness and Response is guided by its Governing Bodies and follows-up on ECOSOC Conclusions, on UNGA Resolutions 46/182, 47/168 and 48/57 and the ensuing processes of reform and inter-agency co-ordination. Following landmark resolution UNGA/46/182, the World Health Assembly passed resolution WHA48.2 that defined WHO's role as a founding member of the Interagency Standing Committee, and WHO is an active member of the IASC/WG.

WHO approaches human survival and health in a broad perspective that encompasses security, medical care, water, sanitation, nutrition, disease control, immunization, family, reproductive, and mental health. WHO's goal is to reduce the avoidable death and suffering that result from any natural or man-made disaster. This goal can be attained only if all the determinants, factors and processes of vulnerability are acted upon, and by taking a life-cycle approach to crises and extreme events: from primary prevention, through mitigation, preparedness response and recovery.

Besides providing technical guidance to all whose work contributes to people's survival, WHO assumes specific operational responsibilities such as health assessment and surveillance, advocacy and coordination with health actors, particularly local and national authorities. WHO vision in this area is one of resilient healthy communities that are prepared to deal with the unexpected and ready to maximise the opportunities coming from external assistance for better relief and prompter recovery.

Causes and features of crises, as well as humanitarian policies and practice evolve continuously: the same as the theory and practice of public health. WHO's work to generate new knowledge in this area and to assist member countries and international partners has to grow accordingly, and this process can only be open-ended.

In closing, WHO congratulates the Emergency Relief Coordinator for his intervention at the beginning of the Segment, and thanks the other agencies and NGO partners, members of the IASC, as well as ISDR for their effective collaboration, in testimony to the tenth anniversary of UNGA 46/182.

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# *RELEVANT IN TIMES OF TURMOIL*

## WHO and Public Health in Unstable Situations

Alessandro Loretti, Xavier Leus, Bart Holstein

## Challenges

The first principle of Health is life, and natural and man made disasters threaten life and health. For millions of people world-wide, surviving the pressure of extreme events, be they drought, floods or war is the predominant objective in daily existence.

One sees countries undergo periodical disasters along apparently immutable patterns. Economic downturns combine with natural or technological hazards and trigger off emergencies wherever or whenever the capacity is lacking to cope with them. The distinction between natural and human-induced disasters is becoming more and more blurred: the consensus is growing that there are no "Natural" Disasters. Natural or man-made hazards impact upon human vulnerabilities that are mostly determined by human causes. Thus, all emergencies can be said to have political causes: either by commission or by omission.

Complex emergencies are but the most blatant instances of this. Some countries have known only armed conflict for the last 25 years and their number is increasing. And the 1990s, with the end of the Cold War and Globalisation, have seen the redefinition of the role of states, sometimes their collapse and the explosion of wars in contexts of extreme vulnerability. Mid-1999, humanitarian sources reported 24 ongoing emergencies, each of them involving at least 300,000 people "*requiring international assistance to avoid malnutrition or death*"[1]. All together, including the countries still only at risk and those emerging from armed conflicts, 73 countries, I.e. almost 1800 million people, were undergoing differing degrees of instability at that time[2].

> *"...This compounding of extreme climatic events with rapid economic and institutional transition - or collapse - presents a complex profile for future disasters. The poor, forced to live on marginal land in urban and coastal areas where jobs are concentrated will suffer most as the planet warms up and disaster strikes - 96 per cent of all deaths from natural disasters already happen in developing countries [.....] The deadly combination of environmental change, economic inequity and political inaction will dominate the future of the humanitarian scene.".*
>
> - IFRC, World Disaster Report 1999

*"Relief- -Development Continuum* " seems to have dropped out of the language of the international community. However, the issues underpinning that paradigm remain. Disasters and development are closely intertwined. Development is about change in human and environmental systems. In a context of fast increasing population and fast economic, technological and social transitions, changes reach deeper and further. They become more radical and less predictable. They can engender crises that are more likely to catch people and societies unprepared, outstrip their coping capacities and lead to disasters.

Change is inherent to human reality and one can define as especially vulnerable those individuals, communities and societies that have least means to influence and cope with the pace and shape of change. The greater the pace and rate of change, the greater the instability and the risk.

> *"When it comes to living in an environment of deteriorating social service delivery systems which ultimately result in catastrophes, people's tolerance levels tend to increase to accept more episodes and interpret them as normal. The longer the situation continues the higher the tolerance level and the less likely another incident or event will be interpreted as dangerous enough to trigger a response"*
>
> - De Rooy C, Shiawl T: Vulnerability analysis, Equipping country offices to beter forecast emergencies in West and Central Afria Region, a study financed by UNICEF-Emergency Operations, Abidjan , Novermber 1996

## Defining Instability*

Instability can be envisaged along a spectrum (Table 1). At one end, "Utopia" represents an ideal all-stable, all-equitable, well resourced society fully integrated and at ease in global geo-

*We use the term instability with a degree of liberty : a system that is unstable is not necessarily bad. Likewise, Chaos refers to a system that lacks evident structure and where prediction is difficult.. Only In public parlance, it means "horrible, fast-changing, high-risk situation and it is used here in this sense. For argument's sake, we use here "Chaos" and/or "extreme instability" to identify situations of high-mortality-risk, where there are more negative health outcomes, or the "likelihood of 300% plus increases in morbidity and mortality."

politics and economy . At the opposite end, in "Chaos", the society is shattered and societal factors lie at the root of the crisis, e.g. because the State itself applies and promotes violence against its own citizenry.The spectrum can be defined by the varying presence and interplay of natural and man-made factors of risk. Natural and/or man -made hazards are absent or effectively managed in "Utopia", while they are left unchecked and free to interact with each other until they "*materialise as disasters*" in "Chaos".

**Table 1: The Instability Spectrum**

| CATEGORIES | "UTOPIA" ◄——► CHAOS" | |
|---|---|---|
| Geography | Easy access, good environmental resource base | Poor access, e.g. landlocked Environmental degradation |
| Climate | Absence of extreme phenomena | **Drought, floods, storms** |
| Geology | No major geological hazard | **Earthquakes, landslides, volcanic eruptions** |
| Biota | Good balance between human systems and potential pathogens | **Epidemics, epizoonosis, pests** |
| Human | Historically homogeneous; "normal" demographic distribution | Unchecked Growth Rate; "Demographic entrapment"; major distortions in sex/age distribution; ethnic diversity and **strife** |
| Economic Infra-structure | Sustainable and equitable availability of natural resources<br>Stable and even distribution of population | **Violent conflict for vital resources**: "*infra-structural*" violence<br>**Forced human displacement** |
| Regional Politics | Good relations with neighbouring countries | **Armed conflict with bordering countries** |
| Economy | Sustainable and equitable growth | **Economic crisis** |
| Society | Social cohesiveness and trust | Social disintegration; **civil strife** |
| Culture | Integrated, open to internal and external factors of change | **Strife among/against minorities**<br>Cultural and political isolation |
| Governance | Good governance | **Structural & repressive violence** |
| International Relations | Good integration in global economy | Marginalisation; sanctions; "criminal" economy |
| State Policies | "Rule of Law" | **Structural & repressive violence** |
| Development Policies | Equity , participation, safety | Inequality; exclusion and violence, **technological disasters** |
| Service Policies | Equitable, effective, sustainable | **Collapse of services & lifelines** |
| Capacities for Emergency Management | In place, updated and sustained | Absent: total dependence on external assistance |
| | **0** ◄—— ——► **+++** | |
| | **Instability Spectrum** | |

At the "Utopia" end of the spectrum, as all surrounding systems are assumed to be in perfect functioning, vulnerability is essentially individual and determined by biological factors. At the "Chaos" end, vulnerability is primarily defined by socio-economic factors and largely collective. Conceptually at least, there is a strong rationale for different public health approaches.

**WHO and emergencies**

All reality has implications for health, whether direct or indirect, and WHO's responsibility for health does not cease in emergencies. On the contrary: as emergencies bring forward extreme challenges to human life, medical and public health ethics make it imperative for the Organisation to be involved. While working at how to optimise its comparative advantages, WHO cannot selectively shed elements of its global responsibilities simply because they are complex or uncertain. Disasters, emergencies and instability are public health concerns: dealing with them so to reduce their impact in terms of illness and death is a fundamental responsibility of public health practitioners. WHO has to enhance its presence and effectiveness in these situations in its capacity of universally accepted advocate for public health.

The plight of people affected by any disaster is incompatible with WHO's definition of Health: Article 2 of WHO's constitution specifies the Organization's mandate to assist governments and special groups in emergency situations. At the same time, human survival and health are obvious cross-cutting objectives of all humanitarian endeavour.

Furthermore as crises become more enmeshed with the crisis of legitimacy of the State and armed conflicts become more directed against countries' social capital, they impinge more on WHO's work. As a UN Specialised Agency accountable to its member countries, WHO has to reconcile its unique responsibility in the health sector, the humanitarian imperative and the mandate to assist its primary constituents.

WHO is not new to disaster reduction, nor to humanitarian action. Already in the 196Os WHO was part of the UN operations in the newly independent Congo[3]. On the strength of that experience and of that of Skopjie's earthquake, compounded by the need to meet the health needs of Palestine's Occupied Territories[4], around 1969-70 the Organization established a unit for Emergency Relief Operations in the office of the Director General. In the 1970s, PAHO's Preparedness Program started translating the epidemiological method into a regional program for disaster reduction. Since, the Organization has never ceased to contribute to this area.

Also in "complex emergencies", well before the term was coined and before UNGA Resolution 46/182[5], WHO had found ways to be effective in, and in spite of armed conflict. In the 1980s, PAHO was a key player in the preservation and restoration of the health sector in Central America, an experience that was to develop concepts of health as a bridge to peace and of integrated PHC for refugee and host populations[6]. In 1988-92 in Mozambique[7] and Afghanistan, WHO played a central role in the first attempts at UN humanitarian coordination. The recurrent crises in the North and Southern Balkans had WHO's Regional Office for Europe develop new approaches - the two most significant, perhaps, the opening of sub-offices to get closer to the affected populations and a declared "political" engagement to "Peace through Health.[8] These experiences fed into various World Health Assembly resolutions and a growing, although uneven, WHO's presence in large humanitarian operations: from The Balkans to Africa's Great Lakes, from Indonesia, Iraq and East Timor, to West Africa and Colombia.

In Somalia, WHO makes a difference in saving both lives and national capacities. In the recent earthquake in Gujarat, it was WHO that ensured the first de-centralized humanitarian coordination in the affected area. WHO's experience of integrated assistance to displaced and host communities as a measure for post-crisis stabilization, in Central America, Mozambique, Sri Lanka and Bosnia Herzegovina[9], is still far from being mainstreamed in the field practice of operational agencies facing "*The Gap*". WHO's cross-border health programs in the Horn of Africa, between the USA and Mexico and between Thai and Myanmar have scarce equivalents in the international scene, at least as far as inter-governmental cooperation is concerned. Major WHO's initiatives such as Roll Back Malaria, Polio Eradication and Making Pregnancy Safer, include specific strategies for operating in complex emergencies. In the most troubled continent, Africa, it is WHO that had its member states adopt regional resolutions on peace as pre-condition for health[10] and on the need for preparedness against all emergencies, natural as well as man-made[11]. WHO presence in the Balkans and in Central Asia strives at combining health policy development with emergency preparedness and

stabilization. In Indonesia, WHO plays an important role in risk monitoring and is strongly committed to capacity building in and programme promotion to foster health as a bridge for peace.

The Organization has specifically recognised that disasters, whether natural or resulting from human activities[12] can and do affect the achievement of health and health system objectives.

Within WHO, the Department of Emergency and Humanitarian Action (EHA) is the instrument for intervention in such situations. Interestingly enough, EHA's predecessor, the unit of Emergency Relief Operations, had been established for WHO to deal with the health aspects of a political crisis: the one in the Palestine Occupied Territories. Resolutions 46.6 and 48.2 of the World Health Assembly define the scope of EHA in terms of humanitarian action, emergency preparedness, national capacity building and advocacy for humanitarian principles. Since 1997, a consultative process on WHO 's role in emergencies and unstable settings has been going on around EHA. After a consultation on what the operational partners expected from the Organization in acute emergencies[13], the process accompanied the global debate in the public health and the humanitarian communities. This debate, that recognises public health as a cornerstone of humanitarian action, is shifting its focus from acute crisis management to mitigation, preparedness, and post-crisis transitions. The question of how to preserve and restore people's health in a vast range of situations of instability is increasingly coming into the limelight.

This process allowed to define WHO's nine Core Corporate Commitments in emergencies (see Box page 6), that is the technical public health priorities that WHO must ensure regardless of the circumstances because key to reducing avoidable mortality and morbidity. On the institutional level, when developing the agenda of their 2nd Global Meeting in March 2001, WHO Country Representatives from all over the World requested that Disaster Preparedness and Response be included as a separate item: in Geneva, they reviewed together the lessons learnt at country level and made important recommendations as to how WHO's responsibilities can be translated into practical activities in context of instability and emergency[14].

**Table 2: The instability spectrum and WHO's roles**

| *Mode* | **Development Mode** | | **Emergency Mode** |
|---|---|---|---|
| *Scope* | Technical | Programme/Strategy/Policy | "*Political*" |
| *Partners* | MOH | International Partners | IASC/WG |
| *Concern* | Individual | Collective | "*unacceptable numbers*" |
| *Focus* | Care | Management | Coordination |
| *Level* | Country/Region | Regional/Global | Global/UN |
| *Responsibilities* (WHO program or department) | e.g. Injury Prevention Mental Health | | Emergency & Humanitarian Action (EHA) |
| **0** "***Utopia***" | | | **+++** "***Chaos***" |

**Instability Spectrum**

**Role of WHO in unstable situations**

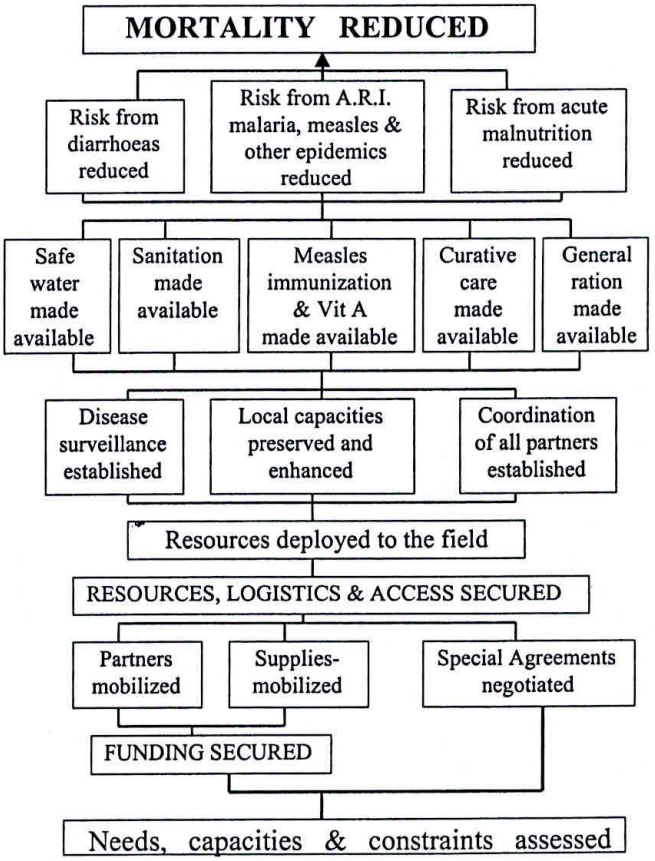
Looking at the " Instability spectrum" WHO's role changes (Table 2): from ensuring a two-way flow of information on new scientific developments in public health in the ideal all-stable, all-equitable, well resourced country, to dealing with sheer survival where the state is shattered or part of the problem. National authorities are WHO's natural partners in "Utopia", while being able to work with/through the "International Relief Community" and a variety of other partners under the umbrella of the IASC/WG* is the condition for effectiveness in "Chaos". In such settings key priorities include coordination of action and contributing to field relief activities, possibly collecting evidence that can help mobilize international political solutions. The greater the instability of the environment, the less health practitioners- the same as those from other disciplines - can do alone, and the wider the vision and the capacity to understand and work in a multi-sectoral complex frame of reality.

**Role and responsibilities are clear: how to satisfy them ?**

WHO poses itself the explicit goals " *to reduce avoidable loss of life, burden of disease and disability in emergencies and post-crisis transitions*" and "*to ensure that the Humanitarian Health Assistance is in line with international standards and local priorities and does not compromise future health development*".

The planning tree depicted in Table 3 was produced by WHO staff during a workshop on Logical Framework Planning applied to complex emergencies[15]. Given the overall goal of reducing avoidable mortality and morbidity (top in the figure), three specific objectives were identified as critical: reducing the risk from diarrhoeas, from acute respiratory infection, malaria, epidemics- first of all measles, and from acute malnutrition**.

**Table 3: Humanitarian response: health goal, objectives, outputs and activities**




Proceeding further upstream, for these risks to be reduced a number of outputs are needed. Safe water, shelter and environmental sanitation need to be in place, together with immunization and distribution of vitamin A, curative health care and appropriate general food rations. Always proceeding from top to bottom, these five sets of essential public health "products" in turn, require to be sustained by precise activities: epidemiological and nutritional surveillance, preserving and strengthening local health capacities, coordinating all operational partners, e.g. for water, sanitation and food to be ensured. This is a good summary of what is expected by health field workers in an emergency

For these activities to take place, resources must reach as close to the needs as possible. This, in turn, requires access, logistic capacities and, of course, the resources themselves. Human and material resources and, partially, logistics, depend essentially on availability of funds that need to be mobilised,

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* Inter Agency Standing Committee Working Group

** the case studies discussed at the workshop focused essentially on Africa: in the context of The Balkans, for instance, greater attention should have gone to the risk for intentional injuries.

Access - and thus, to an extent, logistic options - require that special agreements and procedures are negotiated. This aspect is especially relevant in complex emergencies. However, in different ways, e.g. as standing operating procedures, pre-defined legal provisions, by-laws and delegation of authority, it constitutes a important element of all emergency management systems.

The planning tree "is rooted" in the rapid assessment: of the health needs that must be addressed, of the capacities already in place and of how much else is required so that the needs can be met, and of the constraints that must be overcome -e.g. by negotiating humanitarian access and the assumptions that must be monitored for the project to be successful.

The planning tree reflects with fair accuracy the list of WHO's Core Corporate Commitments. In practice, reducing avoidable mortality and morbidity in emergencies requires that the Organization has the operational capacity in the field and the credibility needed to ensure coordinated Public Health management for optimal immediate impact.

By deploying public health emergency experts, or other specialists according to the needs, WHO can identify priority health and nutrition needs and ensure that these are properly addressed. As long as the rapid health assessment is properly connected with the institutional memory of the WHO country office, the Organisation can also immediately prepare to bridge the gap between relief and recovery, by having life-saving priorities addressed in an integrated primary health care approach, thus preserving and strengthening local health systems. Besides fulfilling the priority humanitarian responsibility, this will also satisfy WHO's mandate in contributing to collective public health learning and health sector accountability.

**WHO Core Corporate Commitments**

- ✓ Identifying priority health and nutrition-related issues and ensuring that these are properly addressed in an integrated primary health care approach that preserves and strengthens local health system.
- ✓ Strengthening health and nutrition surveillance systems to enable monitoring of any changes, early warning of deterioration, and immediate life-saving action through outbreak response and technically sound nutrition interventions.
- ✓ Ensuring control of preventable ill health particularly communicable and vaccine-preventable diseases.
- ✓ Ensuring that risks related to the environment are recognised and properly managed.
- ✓ Ensuring good quality and access to basic preventive and curative care including essential drugs and vaccines for all, with special focus on the especially vulnerable - the elderly, the very young, pregnant women, the disabled and the chronically ill.
- ✓ Ensuring that Humanitarian Health Assistance is in line with international standards and local priorities and does not compromise future health development.
- ✓ Advocating and negotiating for secure humanitarian access, and neutrality and protection of health workers, services and structures as integral parts of public health promotion.
- ✓ Ensuring that the lessons learnt in a crisis are used to improve health sector preparedness for future crises and disaster reduction.
- ✓ Defining an integrated health policy for preparedness, emergency response and post-conflict, for a coherent health sector development resilient to emergencies, to link relief efforts with national capacities and initiate future health system reform.

- WHO/EHA, 2000

Whereas it is true that, WHO's main role is supporting the Ministry of Health through national officers, there is growing awareness that in emergencies this is not always the only nor the best avenue for action. Supporting the Ministries of Health is essential, important and effective in many instances. However, WHO is increasingly recognising the need to take a wider view of the health sector and often to adopt different strategies as well as seek new health-relevant partners. Adopting a precise operational approach, WHO has learnt to decentralize its country activities during a crisis in order to ensure effective coordination of health relief where it is more needed and to improve accountability and credibility[14].

This has been proven by experiences in countries where war, conflict and displacement are combined with a deteriorating health situation, epidemics and a sudden increase of relief

assistance, by donors and NGOs. These experiences formed the basis of the consensus that developed at the 2nd Global meeting of the WHO Country Representatives mentioned above. Looking at the health challenges posed by the current global context , the "role of WHO in emergencies" does not call for further debate. Neither do WHO's responsibilities: among member countries and partners there is fair consensus that only WHO, as the UN Technical Agency for Health, is in the position to meet them unchallenged, Across WHO, high level political commitment is growing. In strategic terms, the next step is now for WHO to achieve deeper institutional understanding and define the *modus operandi* that is more suited to fulfil this role and responsibilities in practice.

## Moving ahead: making a difference and building a reputation

WHO needs to improve its own performance for the benefit of the populations affected by all disasters, as well as in order to fulfil its normative role with additional tools for public health management and to increase its accountability vis-à-vis member countries and international partners. This requires three key pre-conditions: *presence*, *surge capacity* and *institutional support, knowledge and competencies*.

Today, through its Representatives, Country Liaison Officers and Heads of Humanitarian Offices, WHO is **present** in 148 countries and territories worldwide. In addition, WHO sub-offices are becoming more frequent and expand the Organization's operational capacity in special situations: from Somalia to Afghanistan, from the Caucasus to Africa's Horn and Great Lakes regions, from Indonesia to Colombia, from Iraq to Angola. There is growing consensus across WHO that "wherever we feel that something is bound to happen", the Country office needs to be strengthened. In coordination between Country, Region and HQ, dedicated officers are appointed as"EHA focal points" at country level. The strategic objectives are to support national preparedness in the health sector, so that all member countries achieve readiness and self-reliance in the face of disasters, and to ensure that whenever an emergency takes place, a public health specialist is there to provide the first, life-saving action and advice. Furthermore, following the example of PAHO, some strategically-sited WHO offices are being given sub-regional functions for emergency preparedness and response, e.g. to support and monitor cross-border humanitarian operations and capacity building. Similar experiences are underway also in AFRO and are considered in WPRO. They are not yet institutionalised, but represent a positive trend that deserves supporting and replicating.

Whatever WHO's presence at field level, though, an emergency- by definition- calls for extra-ordinary measures and resources. Therefore, WHO needs to have **surge capacity** , to ensure that its public health expertise is translated in concrete life-saving actions. The strategic objective is to provide prompt additional, appropriate public health resources as needed, when and where needed. PAHO's experience is that much can be done by mobilising regional and sub-regional solidarity and expertise. AFRO is in fact consolidating regional rapid response health teams and was quite successful in Mozambique's floods of 2000. However, the reality is that, especially for complex emergencies, the capacity to deploy international reputedly neutral experts through external assistance remains critical. Donor countries, are increasingly demonstrating their capacities and goodwill in this area, e.g. in for the crisis in Kosovo, the earthquake in Turkey and the floods in Mozambique. Thus, EHA is exploring the feasibility for WHO to enter memoranda of understanding with major donors, by which human and material resources would be made available to the Organization for deployment "at 24 hours notice", under arrangements similar to those adopted by OCHA for the UNDAC Team and within WHO for the Emergency Revolving Fund. By appropriate induction briefing and technical monitoring, EHA would ensure that these additional resources are in line with the Organization's corporate strategy, technical views and standard procedures. As a matter of fact, by guaranteeing a prompter and more focused health response in natural and man-made disasters, WHO would also contribute greatly to improving the global humanitarian relief scene.

> "The humanitarian imperative ( the idea that human suffering demands a response) fundamentally differs from the concept of development co.operation....When alleviating poverty through development, the *sustainability* of the benefits of a given intervention is often the overriding indicator of success or failure while the alleviation of human suffering is usually an *indirect impact* of the development process. In humanitarian action, the immediate imperative is concerned with saving lives and alleviating human suffering....Development is widely recognised as a politicised process whereas, historically, humanitariasm was perceived to be independent or neutral... However, most humanitarian agencies today acknowledge that humanitarian aid is rarely non-political and neutral( Greenway, 1999).... Starting with the Hippocratic Oath ( whereby "The health and life of the patient will be the first consideration"), justifications for provision of health services have always been intrinsically anchored in the humanitarian imperative. The Hippocratic Oath makes no reference to sustainability of poverty alleviation. Gro Harlem Brundtland has stated that "Health is the *cornerstone* of humanitarian assistance, its *ultimate objective*, and the true *yardstick* against which one can evaluate needs for, and the overall performance of humanitarian assistance"
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> - Diskett P, Christoplos I: A forward looking study of health contributions in humanitarian assistance Stockholm. Swedish International Development Cooperation Agency, 2000

The tension between the humanitarian imperative and developmental work is considerable ( see,. box in this page) But public health professionals go back a long way in reconciling the apparent dualities of Health versus Disease, and Prevention versus Cure. And, however, WHO is more than a humanitarian relief agency. It is also a UN Technical Agency, a "Learning Organization" that is primarily geared to, and genuinely reflects its Member States' priorities for sustainable public health. The Organization's work in emergencies cannot go divorced from this wider responsibility. Under the pressure of emergencies, it is too easy for external actors to ignore, if not trample over national and local health systems, and bring immediate - and valuable - relief at the expenses of sustainable long-term health outcomes. Aspects of WHO's modus operandi may need to change in order to accommodate the "extraordinary measures" imposed by emergencies, but the Organization's views and concerns remain key for sound public health practice also in emergencies. It is thanks to its so often discussed "special relation" with the national health sector that WHO can ensure that best public health practice in emergencies stem also from the experience and the needs of the beneficiaries and not only from the capacities( or mandate) of external actors. Thus, in order to be effective, WHO's presence and surge capacity in emergencies need to integrate the institutional knowledge, the competencies and the managerial set up of the Organization.

This means that the additional human and material resources deployed to ensure WHO's presence and/or surge capacity are predictably in line with the Organization's corporate strategy, technical views and standard procedures. Meanwhile, WHO country and regional offices need permanent access to technical expertise. Furthermore, their views represent the reality check of this expertise in emergencies, and they must be fed into the Organization's resource-allocation processes and institutional memory, as well as into global action for humanitarian assistance and development.

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