MIP/01/APR.SDE.5
16 May 2001

WORLD HEALTH ORGANIZATION

MEETING OF INTERESTED PARTIES

GENEVA, 18 TO 29 JUNE 2001

Area of work: emergency preparedness and response

Progress Report 2000

RESPONDING WHERE IT MAKES A DIFFERENCE

1. Human survival and health are crosscutting objectives of humanitarian action. WHO aims to reduce avoidable loss of life, burden of disease and disability in emergencies and post-crisis transitions. This is best achieved by being present at the place and moment of need to coordinate public health management, first for immediate relief, and then to facilitate reconstruction and development to mitigate the impact of future disasters.

2. In 2000, WHO was present in a number of major emergencies described below.

3. **Africa's Great Lakes Region: Democratic Republic of the Congo, Burundi and Republic of the Congo.** WHO response has regional and country scopes, with focus on cross-border and cross-line facilitation of health activities. Country offices are active in poliomyelitis eradication, disease surveillance and control, rehabilitation of hospitals and laboratories, reproductive health and HIV/AIDS. The WHO subregional focal point in Nairobi, temporarily discontinued, will be reinstated thanks to support from Sweden, while funding from Norway is helping WHO rehabilitate peripheral laboratories in the Republic of the Congo.

4. **West Africa: Guinea, Liberia and Sierra Leone.** The subregional crisis has caused major displacement and refugee movements. WHO's response addresses the health problems of refugees, displaced persons and the local population by providing technical support to local authorities and relief workers. In Sierra Leone, contributions from Italy and the United States of America helped WHO in health coordination, hospital rehabilitation, surveillance and management of epidemics, and HIV/AIDS control.

5. **Mozambique** faced catastrophic floods, which affected a million people and resulted in displacement of 600 000 persons, destruction of infrastructure and economic degradation in this country

recovering from civil war. The WHO Regional Office for Africa, through the country office, provided technical support to the Ministry of Health, the organizations of the United Nations system and the nongovernmental organizations. Australia, Italy, Sweden and the United Nations Foundation made important contributions to WHO.

6. **Horn of Africa.** A regional drought and the war between Eritrea and Ethiopia forced people into overcrowded camps where malnutrition and disease outbreaks were rife. Emergency stocks were exhausted and health systems collapsed. WHO participated in United Nations assessment missions, and contributed to the regional United Nations Task Force on Long-term Food Security. The WHO office in Ethiopia was strengthened with two medical officers and a nutritionist. WHO also ensured epidemiological surveillance, availability of drugs and vaccines, disease management, nutrition activities, by using regular budget funds and voluntary contributions from Italy and the United States of America.

7. **Somalia.** WHO and UNICEF, together with nongovernmental organizations, Somali authorities and communities, vaccinated 1.3 million children against poliomyelitis, gave other vaccinations and vitamin A to another 500 000. WHO established a rapid outbreak detection and response network in 13 regions. Health authorities in Somaliland and Puntland were strengthened. Other improvements included targeting of nutritional programmes, access to water for over 500 000 people, and a successful programme to accelerate tuberculosis control (supported by Italy and Norway).

8. **Sudan.** WHO's early warning system was instrumental in controlling outbreaks in South Sudan, including Ebola, which threatened to spread from Uganda, and meningitis. National immunization days reached over five million children, who also received vitamin A. Due to funding problems, WHO is able to respond only partially to the meningitis epidemics, which are a major hazard. The only contribution received was an Italian donation for the Nuba Mountains special appeal.

9. **Afghanistan.** WHO has an advisory and coordinating role with the health authorities, United Nations agencies and nongovernmental organizations. The focus of WHO's decentralized presence is to advocate for international health standards and gender-balanced participation, to support health infrastructure and to build national capacities. WHO works in the area of safe motherhood, immunizations and poliomyelitis eradication, malaria, cholera and tuberculosis control, integrated primary health care and community water and sanitation, in collaboration with UNFPA, UNHCR, HealthNet International and Medair. Main contributors are currently Italy, Japan and Norway.

10. **India.** Following the Gujarat earthquake, health and sanitation facilities and infrastructure were severely damaged. Routine immunizations were interrupted. Within 36 hours, WHO staff was mobilized from India, Indonesia and Nepal, and from the Regional Offices for South-East Asia and the Americas, and two sub-offices were set up in Ahmedabad and Bhuj. Thanks to contributions from Italy, the United Kingdom of Great Britain and Northern Ireland and the United States of America, WHO cooperated with the national health authorities and ensured rapid needs assessment.

11. **El Salvador.** The two earthquakes in January and February 2001 caused disruption of the health infrastructure, thousands of injuries, displacement and deterioration of the health situation. WHO/PAHO ensured technical health coordination, promptly deploying experts' teams that supported the national authorities to assess the immediate health needs and to re-activate critical services. The humanitarian supply management system (SUMA) was set up to assist with the arrival of donations. Canada, Norway and Italy made contributions to the programme.

12. **Colombia.** Due to the long-lasting internal conflict, the number of internally displaced persons (IDPs) is dramatically increasing, while violence against health and humanitarian workers has disrupted the provision of health services. In the last two years, PAHO has been assisting local health care providers and nongovernmental organizations by ensuring needs assessment and technical advice and facilitating the mobilization of funds from the Government.

13. **East Timor.** The major constraint in East Timor is the scarcity of managerial staff in the health sector. WHO focuses on rebuilding national capacities and coordinates immunizations, communicable disease surveillance and control, outbreak investigation, training, essential drug policy and related legislation. WHO provides technical support to the World Bank project on health sector development, as well as to maternal health, family planning, control of HIV/AIDS and sexually transmitted infections. WHO activities received the support of Australia, Italy, Portugal, Spain, Sweden, the United Kingdom of Great Britain and Northern Ireland and the United States of America.

14. **Malukus.** Violence between Muslims and Christians has resulted in widespread suffering, destruction, disruption of the health system and internal displacement. WHO participated in several health assessments and delivered emergency health kits. Through the United Nations Humanitarian Task Force and Health Emergency Response Center, WHO coordinates health relief and gives technical assistance on health care delivery, environmental health, maternal and child health, nutrition, epidemic surveillance, preparedness and control, support to health facilities and capacity building. Support for WHO activities has come from Australia, Netherlands, New Zealand and Sweden.

15. **Democratic People's Republic of Korea.** WHO provides technical support on primary health care, poliomyelitis eradication, control of tuberculosis and malaria, pharmaceuticals and essential drugs, and restoration of district services and laboratories. Australia, Norway and Sweden supported the WHO programme.

16. **United Nations-administered Province of Kosovo.** WHO cooperated in developing the Health Policy Guidelines, later endorsed by the United Nations Interim Administration, which helped establish a new health system in Kosovo based on primary health care; WHO also cooperated in developing regulations and quality control capacity for water, sanitation and pharmaceuticals, and addressed maternal and child health, mental health, equitable access to health care for minorities and activities against drug abuse. Support has come from Denmark, the European Community Humanitarian Office, Germany, Japan, the Netherlands, Norway, the Norwegian Aid Committee, Sweden, the United Kingdom of Great Britain and Northern Ireland, and the United States of America.

17. **Palestinian Self Rule Areas (PSRA).** Since the Oslo Accord in 1993, the objective of WHO's presence in the PSRA has been to provide technical assistance and to help develop the health service delivery capacity of the Palestinian Ministry of Health. The Technical Assistance Programme of WHO, which maintains an office in Jerusalem and a suboffice in the Gaza Strip, encompasses all major public health issues. Support has come from Belgium, Italy and Norway.

18. **Iraq.** WHO participates in the implementation of the United Nations Security Council Resolution 986, which enabled Iraq, since 1996, to sell petroleum in exchange for food, medicines and other humanitarian supplies. WHO acts as an observer and verifies the equitable distribution of imported commodities in central and southern Iraq. In northern Iraq, WHO plays a dual role of observer and implementer, addressing public health concerns and the rehabilitation of the health system.

GLOBAL AND REGIONAL ACTION FOR PREPAREDNESS

19. Effective country presence for preparedness and response and surge capacity in time of crisis demand health intelligence - we need to know where something is bound to happen – and clarity of intents – i.e. what we can and must deliver in any circumstance. They require institutional capacities and competencies, i.e. a strong network at field level and synergy between WHO offices, technical departments and programmes, and all operational partners, in an interagency context.

20. While AMRO/PAHO continues to lead the way, disaster mitigation and preparedness are gaining momentum in all WHO regions. Success is testified by interventions at country and intercountry levels, interregional collaboration, easier flow of information and a growing feeling of belonging to a global public health network for preparedness and response. In two interregional retreats, common priorities were identified and views were shared on WHO's role in disaster reduction. In a dialogue between technical departments and country offices, a set of WHO's core corporate commitments was developed, illustrating how the Organization can best fulfil its responsibilities in emergencies. The Field Emergency Handbook was distributed to WHO offices and posted on the EHA web page. A plan for training and competence building has been finalized.

21. In order to improve the quality of health assessments and provide the best possible knowledge of emergency situations, Emergency Health Intelligence is being developed as a core function of WHO. Feedback from users of the Health Intelligence Network for Advanced Planning after the Kosovo and East Timor crises was very positive.

22. In order to provide guidance on best practices to agencies working in emergencies, emergency health library kits, each containing 130 public health guidelines, were distributed to WHO in East Timor, Eritrea, Ethiopia, India, Indonesia, Kosovo, Mozambique, North Caucasus, and South Sudan. The contents of the kits have been transferred to a CD-ROM. Two books were published: *Community emergency preparedness*: *a manual for managers and policy-makers*, WHO, 1999 and *The management of nutrition in major emergencies,* WHO, 2000; a manual on environmental health in emergencies is in print.

23. In order to identify strategic options for WHO in countries undergoing instability, case studies were reviewed and a concept paper is being prepared by the London School of Hygiene and Tropical Medicine. Strategy papers on health and HIV/AIDS in conflicts, IDPs and post-crisis reconstruction were distributed to the Economic and Social Council, the Interagency Standing Committee Working Group, other United Nations and international bodies and within WHO. WHO contributed to the revision of the Oslo Guidelines on the use of Military and Civil Defence Assets in disasters and to the follow-up on the report of the Panel on United Nations Peace Operations (the Brahmi report).[1]

24. In order to provide guidance on peace building skills to health personnel, training was conducted in Indonesia and in Sri Lanka. Country case studies were prepared and reviewed, consolidating lessons for policy design and further training. New projects were identified. An active learning package is posted on the web page. Field experience suggests that training on peace and health should be a standard feature in all complex emergencies.

25. External support to WHO's global activities for preparedness came from Italy, Norway, the United Kingdom of Great Britain and Northern Ireland and the United States of America.

---

[1] A55/305-S/2000/809.