Iraq and “The Others”
by Sandro Colombo and Alessandro Loretti, EHA Department World Health Organization

It may not be true any more that Yugoslavia and Somalia attract the world’s attention, but we have to concur with the anonymous Sudanese author of the epigraph that for people caught in a crisis, the country where (s)he happens to reside can make the difference between dying, surviving or living with dignity.

The world’s eyes are now focused on Iraq, and on the humanitarian, political and financial challenges of its reconstruction, whose scale reminds us of the Marshall aid plan for Europe after the World War II. The risk that new, concurrent crises elsewhere go unnoticed is high. The effects of the Iraq crisis on global funding for humanitarian assistance are yet to be seen: however, in a context of inadequate humanitarian funding, it is likely that aid will be rationed, with resources detracted from other crises to fund Iraq’s reconstruction.

Impartiality is one of the principles of humanitarian assistance and calls for aid to be provided on the basis of need alone, and to be commensurate to it. Statistics, however, make one doubt the rhetoric of humanitarianism. Let’s take the CAP 2000: five countries received less than $10 per capita (North Korea, Somalia, Tajikistan, Uganda and Guinea-Bissau), five received between $20 and $36 per person (Sudan, Angola, Burundi, Sierra Leone and Tanzania), one received $87 (the DRC) and one $185 per person (South-Eastern Europe). In 1998 the two extreme values were $2 per capita for Eritrea and $166 for the Former Republic of Yugoslavia. Even discounting for incompleteness of the CAPs data, the difference in the scale of response is too large for invoking variations in real needs or in costs of operations as explanations for their imbalances. The broad pattern of donor response to emergencies is that of polarisation. Each year one or two countries attract a big share of CAP funding: between 1996 and 2001, with the exception of two years, the two largest appeals have received more than 50% of the funds.

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It seems that other factors, rather than needs, drive donors, and explain differences in resource allocation. A recent study analysed these factors concluding that, contrary to common wisdom, intensified media coverage, the so-called CNN effect, only occasionally is critical in influencing donors. Donor response also depends on the presence and lobbying capacity of humanitarian actors. Not surprisingly, other interests, related to both strategic goals of resource control and security concerns, are much more important in the allocation of aid. Of course all these factors are interdependent: the intensity of media coverage and the presence of humanitarian agencies in a crisis are conditional on a higher level of interest, which ultimately decides the agenda of the media and aid industries.

Analysing why and how a particular crisis attracts donor attention, while another one remains outside the spotlight, can provide only partial answers. In fact, focusing only on one emergency, and overlooking the fact that some emergencies become noisy at the expense of others remaining silent, one risks not to see the wood for the trees. In our globalised world, crises are interconnected,
Is information (or the lack of it) a determinant of humanitarian aid?

The DRC, by any standard the worst humanitarian disaster of the past decade, is, according to the IRC, the ‘deadliest documented conflict in African history’. At least 3.3 million deaths occurred in excess of what would normally be expected between 1998 and 2002. The Crude Mortality Rate of 3.5/1,000/month, for a protracted period, is one of the highest mortality rates reported in the world. In spite of this evidence, scant attention is being paid by donors: so far, the DRC is the country with the lowest amount of pledges in the 2003 CAP.

and for analysing the broad picture we need the help of scholars of political economy. Some observers note that over the last decade, a new security framework has emerged, which interprets underdevelopment and political instability as threats to global governance and its expansion. According to this framework, underdevelopment causes conflict, terrorism, criminal activity, illegal trade and population displacement, thus threatening global security. A policy shift has, therefore, occurred, with aid becoming ‘a part of a global project to exert political control at the margins’ (Macrae). The Balkans, Afghanistan and Iraq crises are the most obvious examples of this shift, whose main features are the merging of politics, military interventions and humanitarian assistance to pursue foreign policy goals and the exceptional amount of aid infused in these crises. Another known fact is that in the same emergency there are silent and noisy areas -or sub-emergencies- that depend on local balances of power, military strategies, trade of legal and illegal goods, etc. Humanitarian assistance is, by omission or commission, another governance tool at all levels.

Afghanistan is a case in point of the politicisation of humanitarian aid, and of the cyclical shifting between the status of silent and noisy emergency. During the Cold War, Afghanistan received substantial aid, targeting mainly the resistance-controlled areas (even if humanitarian needs were equally high in the government areas). When the Russians withdrew in 1989, the country disappeared from the agenda of western countries and humanitarian budgets were dramatically reduced. During the Taliban regime, tight aid conditionalties were imposed: withholding aid did not produce, however, the desired political changes, and in the words of Boutros Ghali “Afghanistan became one of the world’s orphaned conflicts, the ones that the West, selective and promiscuous in its attention, happens to ignore in favour of Yugoslavia” . After September 11th, and the subsequent military intervention, the country was flooded with aid. Now, with the Iraq crisis, Afghanistan sees signs of donor fatigue, while humanitarian needs are still high, the reconstruction of the economic and social infrastructure has just started and insecurity is widespread. According to the CAP midyear review, Afghanistan is now in the lower end of donor response, with only 27% of requirements covered so far.

The aid mathematics

The graph below shows the trend of spending for humanitarian aid and its share of Official Development Assistance . In absolute figures, humanitarian aid has increased ten fold, and its share of ODA four fold. These figures need, however, to be put in perspective: when seen as a percentage of the growing major donor’s wealth, humanitarian aid has in fact decreased by more than 35%.

The requirements for the Flash Appeal for Iraq total $2.2 billion for six months. Projected to one year, this extraordinary amount of money represents more than 70% of the total humanitarian aid of 2002. If these requirements are not covered by new, additional funds, a condition that seems difficult to materialise, funding for Iraq will come at the expense of other crises in the world. Moreover, when considering the deepening global recession, one can anticipate that spending for aid will not grow proportionally to the increasing humanitarian needs. The gap between noisy and silent emergencies will, therefore, widen. As the WFP director pleaded few months ago, 40 million people in Africa are starving as the world watches Iraq.

Is Health forgotten?

The issue of the unequal allocation of humanitarian aid among sectors, and the question of whether Health is under-funded require further studies.

However, facts speak: health requirements represent only 10.5% of total needs in ongoing CAPs; as of May 2003, contributions for Health amounted to 10.7% of total requirements. In absolute terms, Health is one of the most underfunded sectors. Ten percent is also the share of aid to health in relation to global ODA. It must also be noted that, in comparison to other sectors (e.g. food, water,
Health service delivery is expensive, even if we deal “only” with PHC: it is labour-intensive, it requires a mix of sophisticated inputs and must be sustained by strong support and management systems. This is all the more true with more developed health systems, like in Iraq, where adequate funding of the sector would require as much as two billion dollars per year. These elements, which are self-evident to health professionals, are difficult to convey to some donors, who tend to equate health relief to the provision of drug kits. The strongest argument we have at our disposal for advocacy is that the main goal of humanitarian assistance, from any sectoral angle we take, is to avoid unnecessary suffering. Thus, health care is critical to ensure the cost-effectiveness of all other sectors’ operations and health indicators are key to the monitoring of any relief intervention.

This issue of our newsletter focuses on a selected number of major emergencies that risk to be forgotten due to the crisis in Iraq, and analyses the health consequences that the determinants of the emergency, together with the reduced level of response have caused. These articles remind us of our responsibility, as health professionals, to advocate for Health to be given higher priority in donors’ and foreign ministers’ agenda, and, as humanitarian workers, to give voice to silent emergencies.

Endnotes


3 CAPs’ contributions represent only 30% of total humanitarian assistance, see T. Porter: ‘Noisy’ emergencies. An embarrassment of riches; Humanitarian exchange, ODI, July 2002: 2-4

4 T. Porter, ibidem

5 GR Olsen, K Hoyen and N Carstensen, 2003 see above

6 M.Duffield: Global governance and the new wars; Zed Books, 2001


10 ibidem

11 ODI, HPG Briefing nr.4: Financing international humanitarian action: a review of key trends, November 2002

12 from 0.35% of GNP in the 1980s to 0.22% in the 1990s; ODI: Financing international humanitarian action: a review of key trends; ODI HPG briefing, November 2002


Measuring humanitarian need: A critical review of needs assessment practice and its influence on resource allocation, Overseas Development Institute, May 2003

The study found broad agreement within the humanitarian community around four related ‘core’ elements of particular concern: the protection of life, health, subsistence and physical security. Against these four criteria, the study found the following in the assessment and analysis of needs:

• The needs based approach, prevalent within the sector, encouraged a supply-driven analysis of requirements.

• The tendency to apply relative standards in chronically high-risk situations led to a disproportionate pattern of aid distribution and neglect of such situations.

• Decision-making within the sector was taking place in the absence of crucial information. The lack of demand for formal assessments reflected an agency and donor ambivalence towards measuring the impact of humanitarian action.

• The definition of a humanitarian crisis was found to be largely a matter of subjective interpretation.

• Humanitarian responses may be driven as much by extraneous factors as by evidence of need, in particular, by the political interests of donors and the marketing interests of agencies.

International efforts to curb global terrorism pose major ethical dilemmas which threaten the legitimacy of humanitarian agencies, according to the World Disasters Report 2003, released on 17 July by the International Federation of Red Cross and Red Crescent Societies. The Report, in its 11th year of publication, highlights the increasing shift by donors and humanitarian agencies towards high profile aid efforts in geo-strategic conflicts such as Iraq and Afghanistan, while chronic emergencies in countries such as Angola, Somalia and the Democratic Republic of the Congo receive little attention.

In April 2003, US$ 1.7 billion of relief and reconstruction aid was raised by the US Department of Defence for Iraq. This figure stood in stark contrast to the US$ 1 billion shortfall in funds then faced by the WFP to avert starvation among 40 million Africans across 22 countries. In Angola, where more than 4 million people depend on humanitarian assistance for survival, the International Federation launched an emergency appeal in September 2002. Four months later, it was less than 4 per cent covered.

“We are facing a real inequity in global humanitarian practice where many of the world’s wars and disasters have become forgotten emergencies. If the aid community and donors are committed to providing aid on an impartial basis they must act on their principles and intervene where the needs are most acute,” says Juan Manuel Suárez del Toro, President of the International Federation.

The Quality of Money: Donor Behaviour in Humanitarian Financing, Humanitarianism and War Project, Tufts University April 2003

• Domestic and international policies, rather than humanitarian principles, are the primary determinants of donor decisions on humanitarian financing.
• The donor humanitarian policy framework is inconsistent and contradictory. Donors have no explicit policy to guide their choice of assistance channel and the process of resource allocation is rarely based on institutional merit.
• The whole of the humanitarian endeavour is less than the sum of its parts. The overall effectiveness of humanitarian aid is compromised by donor earmarking, short funding cycles, unrequited pledges and late funding, and by tying contributions to conditions and political interests.
• A high level of distrust and antipathy was found to be prevalent among donors and implementing agencies. This has resulted in a high level of micro-management, tight earmarking and a disproportionate donor focus on results and codes of conduct.
IN THE AFRICA REGION

During the past five years, around 5 million people have died due to humanitarian crises in Africa and many millions have been displaced or suffered from debilitating illness. With weak health institutions, chronic instability and a high disease burden, the African Region is particularly prone and vulnerable to extreme events that are complex, varied and particularly severe. All countries of the region are at risk and nearly 30 out of the 46 countries are grappling with natural or man-made disasters. Epidemics, earthquakes, volcanic eruptions, floods, droughts and cyclones cause damages, massive displacement, diseases, death and disability, and deep suffering. This wide range of natural disasters is compounded by man-made events: from industrial incidents to food shortages and armed conflicts resulting from political and ethnic unrest.

There is a spectrum of situations from the acute crises in Liberia and Burundi, to the long-running, provincial-level presence of refugees in the otherwise relatively stable Tanzania. Some countries, such as the Democratic Republic of Congo, Uganda, Cote d’Ivoire and Sierra Leone have disappeared from the limelight because of “international fatigue”, only to re-emerge at the brink of chaos, like Liberia and Burundi.

Disasters result in the massive destruction of health infrastructures and other social fabric and further hamper access to health services whose coverage and effectiveness are already low. About 20% of disasters worldwide occur in Africa, but 60% of all deaths resulting from disasters occur in the region as a result not only of its high vulnerability but also its inability to provide appropriate response. Women and children make up 80% of the population and disasters result mainly in high maternal and infant mortality. The numerous crises foster epidemics, rapid spread of communicable diseases such as tuberculosis and HIV/AIDS, whose prevalence ranges from over 10% among displaced persons in West Africa to over 30% in areas affected by famine in Southern Africa.

There is a trend to “sub-regional complex emergencies” characterised by:

- mainly political causes, with economic compounding factors such as in West Africa and Central Africa
- or more economic causes with serious political spin-offs such as in the Horn and Southern Africa

In West Africa, the Liberian conflict has caused at least 600,000 deaths and displaced millions. The Sierra Leone crisis in 1991, the crisis in Guinea and the conflict in Côte d’Ivoire caused the movement of over 2 million people and the death of hundreds.

In Southern Africa, weather vagaries, structural poverty, HIV/AIDS, the heritage of armed conflicts, political instability, economic transition in some countries and collapse in some others, have interacted for at least 12 months in a crisis affecting six countries and threatening at least 14 million people.

The recent earthquake in Algeria claimed more than 2,300 lives and left almost 15,000 people wounded, 200,000 homeless and 2,113,000 affected by the earthquake. The loss in financial terms is estimated at US$ 5 billion.

In the Horn of Africa seven countries know desertification, seasonal floods and periodic drought. The current food shortages affect millions of people. Man-made disasters, intra and inter-country conflicts, widespread poverty, high levels of population growth (in excess of 2.5% annum) make this Sub-region one of the most vulnerable in the world: “the poorest of the poor”.

The economic impact of these crises aggravates persistent poverty. In 2000, floods in Mozambique caused economic losses of more than US$ 427 million. In 2002, economic losses due to crises were estimated at about US$ 15 billion in the region as a whole.

For WHO and all health partners, priorities include the development of a sustainable institutional base and national capacities for emergency preparedness, response and rehabilitation. Meanwhile, urgent interventions are needed to reduce the consequences of on-going crises.

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Southern Africa Crisis

At the launch of the (CAP) Regional Appeal in July 2002, the UN broadcast that 12.8 million people in Southern Africa were facing food shortages, disease outbreaks, spiralling poverty and deterioration of social services. It was declared that urgent support was needed throughout the region to carry out a massive food aid operation and sustain vital social sectors. On September 2002, that number increased to 14.4 million. It was becoming obvious that HIV/AIDS was at the centre of the unfolding crisis.

Today the situation in Southern Africa can still be defined as a crisis of food insecurity, poverty, HIV/AIDS, and governance. The most striking aspect is the devastating
Liberia

Fighting in Liberia has intensified again over the past few months. It has spread more widely in the North, East and West and is now in the capital, Monrovia. Fighting takes place in areas hosting IDPs, returnees, and refugees, and has led to further displacement. Latest available figures estimate that 45,000 Liberians have returned and 40,000 Ivorians have entered Liberia (UNHCR, 07/03/02). In addition it is estimated that 12,000 nationals of third countries, especially nationals of Burkina Faso have entered the country.

Degradation of security has caused many people to be cut off from all assistance. Donors’ response to the Liberian crisis has been very low so far. Notably, the UN inter-agency Consolidated Appeal for 2003 has only been 2% funded to date. (OCHA 25/03/03)

Guinea

It is estimated that between the upsurge in violence in Cote d’Ivoire and March 1st 2003, 18,000 Ivorian and Liberian people have entered the country, as well as 12,000 foreign nationals in transit, adding to the near 100,000 refugees already settled in Guinea. (OCHA 27/03/03)

Sierra Leone

While the situation of the population of Sierra Leone is improving, the country has still to recover from a 10 year war. The security situation is still tense at the border with Liberia and refugees from Liberia are seeking refuge in Sierra Leone. Their nutrition situation is considered at risk.

Cote d’Ivoire

Following a September 2002 coup attempt, about half of the country is controlled by rebel forces. A peace agreement was signed between the government, the armed opposition and the political opposition in January 2003. But security is still volatile, especially in Abidjan and in the West of the country, near the Liberian border.

It is estimated that 600,000 to 800,000 people may be internally displaced. More than 42,000 Ivorians have fled, mainly to Liberia and to a lesser extent to Guinea.

The health sector is especially affected. WHO estimates that in the rebel controlled areas, 85% of the medical staff have left and that 70% of the health infrastructure has been closed. (WHO 12/02/03) A measles outbreak was reported in the West of the country. (OCHA 07/03/03)

Different vulnerabilities among the population have been identified. In the area where a high number of IDPs have sought refuge with relatives, food security may worsen rapidly as the resources are shared between the residents and IDPs. In the towns, loss of employment and an increase in food prices may affect food security of the urban population.

Excerpts from the Report on the Nutrition Situation of Refugees and Displaced Populations (RNIS 41) UN Standing Committee on Nutrition
Burundi: Imagine this headline....

The ongoing confrontation between Anopheles mosquito and Burundians claims 784 lives and 1,128,987 wounded between January and June 2003!

The deadly malaria parasite is indeed a weapon of mass destruction and the Anopheles mosquito attacks indiscriminately. In Burundi, over the past six months 784 people died from malaria and 1,128,987 were treated for it; four people die every day in this fight. In Burundi, after ten years of civil war, this fight is unequal. People’s defences are weakened by displacement, malnutrition, limited physical and financial access to treatment, and elevated costs and scarce availability of impregnated bed nets.

But none of this would appear in the media. Burundi is mentioned occasionally, when fighting intensifies or when a new government is sworn in or a Security Council mission is visiting. In July, media agencies reported on the 200 deaths that occurred in Bujumbura when a group of rebels infiltrated the residential areas. Deaths from malaria, diarrhoea, respiratory infections or complications of pregnancy, rarely receive attention.

It is true that rockets and bullets make more noise, scare everybody, destroy houses, and leave blood stains in their wake. Thus they succeed in attracting the attention of the media. Whereas Anopheles attacks silently, barely a buzz, leaving loads of malaria parasites.

The civil war in Burundi and its burden of deaths, wounded and displaced, destruction and the resulting human suffering are unacceptable. They should always capture our collective attention and call for our most effective responses. But the same needs apply to the “malaria war”, the “diarrheal diseases war” and the threats posed to people’s survival by other conditions. We talk about the “diarrheal diseases war” and the threats posed to people’s survival by other conditions. We talk about the “malaria war”, the “diarrheal diseases war” and the threats posed to people’s survival by other conditions.

Ethiopia: A Cry for Help

Estimates reveal that over 25% of children in Ethiopia’s Southern Nations Nationalities and People’s Region (SNNPR) are below 70% of normal weight for height. These children are in imminent danger of dying from infectious diseases related to severe malnutrition.

Ethiopia already has a high child mortality rate: one out of every ten children does not live to see its first birthday. Nearly two out of every ten children do not live to see their fifth birthday.

The size of this emergency demands urgent assistance: now, almost 20% of all Ethiopians (12.6 million people) are affected by the drought and areas never before affected, like the SNNPR, are now suffering severely. The people in this and other regions will not have the balanced nutrition they need to survive and remain healthy until, at the earliest, the harvests at the end of the year. Adults are also affected and the rates of malnutrition, morbidity and mortality are rising. Emergency food aid to Ethiopia has reached 90% of the levels appealed for as of May 2003; however, it has become obvious that food aid alone is not enough.

Ethiopia is suffering from a severe malaria outbreak, a disease linked to the rainy season. Incidence rates are on the rise. People will continue to die unnecessarily unless bednets and malaria treatment are made available and anti-mosquito spraying is started. Malaria is not the only concern, meningitis will soon follow.

The Government of Ethiopia, together with its UN and NGO partners, is proposing to establish an additional 25 therapeutic feeding centres (TFC) in SNNPR and other drought-affected areas.

Two actions are key: a) developing a proper nutritional protocol, so that children, once at the TFC, receive the proper food and food supplements, and b) training health personnel to treat the malnourished. WHO is urgently requesting donors to support Ethiopia in preventing an upsurge in child mortality. In the longer term, WHO sees assisting the Government of Ethiopia in the general reduction of people’s vulnerability to malnutrition as a priority area of cooperation in order to move from relief to a long term solution.

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Sudan at a crossroad: health challenges and WHO’s strategy

Sudan is closer to peace than ever in its recent history. When peace is signed, the government of Sudan and the rebel group SPLM/SPLA will have put an end to one of the world’s most prolonged and intractable conflicts. Thus, the country will be in a position of emerging from a long-lasting international oblivion. Given the scale and duration of suffering, Sudan deserves increased international attention and assistance: the civil war spans more than four decades; it is estimated that it has led to more than 2 million conflict-related deaths and over 4 million people displaced. Well over 50% of Sudan’s population lives below the poverty line. All health and nutritional indicators converge to depict an unacceptable reality. The country and its international partners must be quick in grasping the current opportunities of peace and recovery. The role of international partners, and of WHO in the health sector, is even more urgent because war has drained human and financial resources away from social infrastructure. Additionally, it is unlikely that the antagonisms of power, interest, and identity that have spawned civil violence for so long will immediately disappear after the cessation of formal hostilities. In this context, WHO and the other international agencies have increased responsibilities in the transition to effective peace.

Access to an equitable and financially fair health system is critical to the fulfilment of the basic right of the Sudanese people to healthy and sustainable livelihoods.

WHO recognises five specific strategic directions for the health sector in the next 5 years:

- Health deserves a central position in Sudan’s broader peace and macro-development agenda. Advocacy is needed and a strong commitment to policy formulation, priority setting and strategic planning for the health sector;
- Sudan needs health systems that are equitable and fair, i.e. that are based on a comprehensive view of the determinants of health: technical leadership and capacity building are needed to support integrated delivery of services through primary health care, public-private partnerships, research, health intelligence and monitoring;
- Sudan’s burden of mortality and morbidity must and can be reduced: selected programmes need to address priority and emerging issues, promote healthy lifestyles and better quality of life with a special focus on the most vulnerable and underserved segments of the population;
- Sudan’s exceptional circumstances and the fast pace of changes pose extreme challenges to people’s survival and healthy livelihoods; greater knowledge, more institutional resources, human capacities and new mechanisms are needed for an effective response to all health aspects of emergencies, humanitarian assistance and the peace process.

WHO cooperation with Sudan will have to be sufficiently flexible to progress and to respond to the emerging requirements of national macroeconomic policies and the peace process in the country. WHO’s unique responsibilities, the demands of the peace process and the challenges of health sector recovery, require consolidated planning and management for the entire country and a reallocation of resources. In the coming five years, in Sudan, WHO will have to:

- shift from mere programme support to strategic planning and management;
- decentralize technical presence across the country;
- build new partnerships and alliances across and around the health sector;
- upgrade its structures to gain greater operational and administrative flexibility.

It is difficult to foresee which will be the political repercussions of the Iraq crisis on Sudan. It is likely, however, as it is mentioned in the editorial, that Iraq will siphon aid away from other crises. It is important, therefore, to bring Sudan back into the spotlight to ensure that the window of opportunity brought about by the peace process is not lost.

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Somalia

The deterioration that war has brought into social, economic and political systems places the lives and livelihoods of most Somalis in constant jeopardy. Only basic coping mechanisms allow the most vulnerable - totalling about 750,000 - to maintain a finger-hold on survival, at levels far below acceptable: they have scarce, if any, capacity to maintain even the most basic assets. Humanitarian access to these groups remains intermittent: in the southern, central and north-eastern parts of the country, violence has increased. Somalia ranked among the least five developed countries in UNDP’s 2001 Human Development Report; in 2003 it is mentioned in (a footnote of) the same Report as one of the countries “for which the HDI cannot be computed”.

In sharp contrast to this picture, hope can be found in the people of Somalia themselves. The challenge of the international community is to take advantage of opportunities Somalis have created through their own initiatives. Local authorities in several areas are cooperating with international partners to broker humanitarian access agreements based on International humanitarian law.

Politically, the Intergovernmental Authority on Development (IGAD) sponsors a national reconciliation process that progresses, although with many hurdles. Bringing stability, security and basic services to the Somali people requires long-term engagement from the international community. UN and NGOs face chronic under-funding. The current CAP is only 26% funded at the mid-year point, and a further US$ 53 million is needed to fulfill current requirements. Areas of particular under-funding are education, health, water and sanitation.

Afghanistan

Following years of conflict, instability and specifically the recent overthrow of the Taliban regime, Afghanistan has begun a difficult period of reconstruction. Providing basic health care is an important part of rebuilding the infrastructure in Afghanistan.

The new Ministry of Health framework, called the Basic Package of Health Services (BPHS), forsees four layers for implementation:¹

- One 50-bed first referral hospital per 100,000-300,000 population;
- One Comprehensive Health Centre per 30,000-60,000 population;
- One Basic Health Centre per 15,000-30,000 population;
- One Health Post per 1,000-1,500 population.

The total cost, based on a population of 30 million, is estimated at US$ 4.55 per capita per year. The cost of the first layer is estimated at $1.13 per capita per year, the second and third layers are estimated at $2.41, and the cost of the fourth layer, the Community Based Health Care system, is estimated at $1.01. About $120 million per year would pay for the BPHS for the entire Afghan population.

Security, the upcoming elections and the national solidarity programme, receive more political attention than public health. In addition, governmental revenues are small: for the foreseeable future, the State will be able to contribute little to public health expenditure, and Afghanistan will need international support. The main donors are the European Commission, USAID and the World Bank, each good for about US$ 20 million per year for the next three years.

The Ministry of Health has accepted a split between its policymaking, regulatory, monitoring and supervisory tasks on the one hand and on the other hand service delivery, that is sub-contracted to NGOs.

It is possible to mitigate the impact of waning interest for the Health sector in Afghanistan. There is donor money for health care, especially for very poor countries. The issue is how to tap this money. Ministry of Health should prepare for a Sector Wide Approach or “basket funding arrangements”. For this to occur, it needs a central finance department up to international standards. In addition, it needs its own professional information department to keep the plight of the Afghans, together with the achievements of their health care system, on the agenda of the global community. Sluicing donor money through the MoH does not necessarily mean that the State would revert to becoming the main service provider. It is actually quite envisageable, and probably desirable, that the MoH continues subcontracting health service delivery to NGOs. Sustainability will hinge on the ability to perpetuate this vision, combined with serious attempts to reform an inefficient civil service.

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Endnotes

¹ A Basic Package of Health Services for Afghanistan, Transitional Islamic Government of Afghanistan, Ministry of Health, March 2003/1392
In 1989, the Socialist Federal Republic of Yugoslavia disintegrated through a series of violent conflicts within the former six republics. A complex humanitarian crisis continued from 1991 until the winter 1995, then flared up again in Kosovo and resulted in the NATO intervention in spring 1999 until June 1999. The Former Yugoslav Republic of Macedonia was on the verge of a civil war in the spring of 2001.

The Balkan crisis had devastating effects on the population. At one time it was headline news and received a great deal of attention and aid. The crisis continues, but the media and donor attention have moved on.

There are still many challenges to be overcome in order to improve the health indicators in line with the Millennium Development Goals (see page 16) and WHO European Regional targets. The challenges are now mainly developmental, but low societal resilience equates to instability and unpredictability: any emergency is very difficult to respond to in time. In this context, the achievements and the experience gained by the different WHO/EURO Humanitarian Offices in the field constitute a valuable point of reference for the work of the Organization.

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Former Yugoslav Republic of Macedonia

When in 1999 the Former Yugoslav Republic of Macedonia proclaimed independence, the neighbouring countries were hostile and the country had a sizeable Albanian minority. During the Kosovo refugee crisis in 1999, Macedonia received 350,000 refugees, the majority of which returned to their homes soon thereafter.

In 2001, an internal conflict between the Albanian minority and the Government displaced 170,000 people. With massive international engagement the crisis was brought to a peaceful resolution in August 2001. However, despite political and constitutional changes the country is still prone to political instability and intolerance. “Isolated” violence is a part of everyday life in FYR Macedonia.

The country is also prone to natural disasters like earthquakes. Coordination between local health authorities and international organizations and public health projects with built-in elements of emergency preparedness, add value in dealing with “smouldering” emergencies and mitigating the impact of sudden-onset disasters.

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Albania

Ten years after the onset of the economic transition, Albanian health authorities are struggling to overhaul a system in need of modernization at a time when public financing has reached historic lows. Albania is characterised by a wide gap in both economy and education between cities and the rest of the country.

Outside of Tirana, a large portion of the Albanian population has limited or no access to health care. In 2002 the maternal mortality rate was 31 per 100,000 live births and infant mortality was 25 per 1000 live births (the highest rates in Europe). The poor are extremely vulnerable and the problems they face in their everyday lives include the risk of epidemics, a lack of health services and in particular the absence of care and support for people living with HIV-AIDS.

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UN administered province of Kosovo (Serbia and Montenegro)

Since the full-scale war initiated in 1998 in the former Yugoslavia, which escalated to the NATO campaign in 1999, the province of Kosovo has been the theatre of continued and internal clashes. Since 1999, the province is under UNMIK administration and has experienced a massive and continuous presence of international humanitarian agencies in the health sector.

This has had a positive impact in strengthening the public health system; however, primary health care services are still struggling to reach the whole population, and hospitals are still debating what they can deliver in terms of clinical services. Problems remain, such as substandard qualification of some professionals, old-fashioned organization and lack of management skills, neglected and poorly maintained infrastructure and outdated equipment. The reform of the health system has not been finalized. The system is over-medicalised with no plans and policies for public health and preventive medicine.

After 2001 external funding started decreasing, but donor contribution is essential for sustainable improvement and
strengthening of the primary level health services and for Kosovo to move towards a more sustainable development strategy.

For further information please contact Dr. Serap Sener at who@ipko.org

Serbia and Montenegro

Ten years of sanctions and isolation from social, political and economic global changes left Serbia and Montenegro economically very weak. The main challenges are a weak economy, weak institutions and a lack of democratic practices in governance. Efforts and resources need to be put into addressing these challenges and supporting the society to take ownership of the process.

After the downfall of Milosevic’s regime in autumn 2000, the country has entered an economic transition that in this first phase puts additional strain on the government to care for the increasing number of vulnerable people. After the autumn 2000 the country faced a breakdown of social services. In addition to high rates of unemployment there are still thousands of refugees and IDPs.

Most of the international agencies are closing down humanitarian programmes and shifting the residual burden of the humanitarian case-load onto the government. The WHO office advocates for a “transition” form of assistance (humanitarian - transition - development) that would deal with the remaining humanitarian needs in a clear exit strategy, with the government as partner.

For further information please contact Dr. Luigi Migliorini at lmi.who@batut.org.yu

Crisis in Chechnya

In Chechnya, the persistent conflict, the destruction of the infrastructure and the scarcity of humanitarian actors able to work under extreme insecurity suggest that the health needs of the 800,000 population far exceed the available resources. Due to ten years of unrest and destruction of medical services, health needs remain unmet. The most vulnerable groups of the population, including internally displaced persons (IDPs), are threatened by a range of risk factors, stemming from endless hostilities, impoverishment and the collapse of civil society. Drastic deterioration of the physical and emotional living environment, overall decline of hygiene and particularly of water and sanitation systems, increasing alcohol and drug abuse, poor diet and lack of access to appropriate health services are all factors contributing to widespread ill health.

For Chechnya, lack of reliable data is absolute, starting with the size of the remaining population. According to various sources, the population is ranging from 800,000 (UN CAP 2003) to 1,100,000 as indicated by the official census. The UN estimates that 140,000 remain displaced in 2002, while for 2001 the MoH reported a total of 13,100. At present, the 53 major medical establishments that can be assessed often lack an electricity supply, have limited water provision and reportedly rarely receive medicine and equipment from federal sources. The process of reconstruction and rehabilitation of the infrastructure, including medical facilities, remains slow and in many cases non-existent.

Several UN agencies are active in the health sector along with an estimated 34 NGOs. WHO is responsible for the coordination of health activities with the exception of water and sanitation. Although attention to health, in its broad sense, is attracting significant support from the NGOs, it does not seem to receive the same priority in the UN Consolidated Appeal Process (CAP). The proportion of the CAP budget earmarked for health has notably decreased from 19% in 2000 to 11.6% of the total amount requested in 2003.

This is an excerpt from the Review of WHO Humanitarian Programs in North Caucasus (Russian Federation) - 2002

Humanitarian Action Plan for the occupied Palestinian territory

The current humanitarian crisis began two years ago and has deepened as closures and curfews seriously hamper the movement of people and goods between cities, villages and refugee camps both inside the occupied Palestinian territories and Israel. These closures have effectively divided the territories into about 50 isolated pockets. Thus, a crisis of access and mobility is compounded by an economic downturn that severely limits the ability of the civilian population to purchase and access basic needs, health care included.

Agricultural production is in decline. As a result of income, food consumption patterns are changing, leading to increased rates of malnutrition and anaemia, particularly among children and women; currently, 50% of the Palestinian population relies on some form of food assistance.
The IDP and health crisis in Colombia

For decades Colombia has been suffering from an internal conflict that has been generating continuous displacements. Recent analysis points to a steady upward trend and estimates that hundreds of thousands of people are displaced. In 2002, 412,553 people were displaced which represents 1,144 daily, a 20% increase compared to 2001 (Consultancy for Human Rights and Displacement - CODHES). The Social Solidarity Network, the Government entity responsible for assisting the displaced population, has registered and provided humanitarian assistance, along with other organizations.

Of Colombia’s neighbouring countries, Ecuador has had “the largest increase in Colombian refugees and asylum seekers”. The number of Colombians that have requested refugee status between January 2000 to April 2003 reached 15,861 people.

The response of the current government to this challenge is a “Policy of Democratic Security”, which focuses the action of the State on facilitating the return of IDPs. The goal is to return 30,000 families. The government recognizes that it cannot respond alone and calls for help from the international community and especially the United Nations. A Humanitarian Action Plan was elaborated last year by the UN team in Colombia to identify gaps in the humanitarian response and draw attention to the crisis. But it has not created the impact expected in the donor community. A permanent lobby in Colombia and in the neighbouring countries for coordinated provision of health care and sanitation services to the IDPs and refugees remains a critical need.

For further information please contact M. Zaccarelli-Davoli at zaccarem@col.ops-oms.org or refer to the web site: http://pagina.de/desplazados

Endnotes
1. ICG. Colombian’s Humanitarian Crisis. June 9th 2003
HAITI: a silent emergency

In the last 10 years, Haiti has seen a slow degradation of all the basic socioeconomic indicators. A total of US$ 500 million in development assistance promised by donor countries and US$ 146 million in Inter-American Development Bank loans for the health and education sector are on hold on the grounds that Haiti has not shown sufficient commitment to a democratic governance.

In a country like Haiti, public health gains are easily lost and it is a well known fact that information systems are the first casualty of crises. In Haiti the routine information system of the Ministry of Health is not covering enough of the population to be relevant. However, withholding humanitarian assistance just because data are insufficient to show the deterioration of the health indicators does not make sense.

The devaluation of the Gourdes in relation to the US dollar has influenced the access to health care for the most vulnerable groups. It resulted in a 31% increase in prices of drugs and users’ fees and a decrease in drug consumption. The Ministry of Health attempted to subsidize drugs but could not sustain the economic burden for more then 3 months. Most health programmes depend entirely upon foreign assistance and fade away when funding is finished. Various studies estimated the HIV prevalence in 15-49 years at 7-10% in the urban areas; blood transfusion is a perilous affair as less and less reagents are available to ensure blood safety.

After five years absence of measles, an epidemic was declared in 2000, affecting mostly the metropolitan area.

An epidemic of polio in 2000 affected 8 children.

From 1995 to 2000 the maternal death rate increased from 457/100,000 to 523/100,000 and life expectancy diminished from 55 to 53 years.

The discussion between donor agencies, financial institutions on one hand, and humanitarian and UN agencies on the other, on whether Haiti is in an acute or a silent emergency has gone on for some time. However this debate has failed to clarify how the humanitarian imperative to save lives fits with longer term developmental objectives or the foreign policy objectives of donor countries.

For further information please contact D. VanAlphen at vanalphe@paho.org

Endnotes

Global Humanitarian Assistance Flows 2003, Development Initiatives, May 2003:

Summary of Key Findings from the Humanitarian Financing Studies: Existing data collated by the Development Assistance Committee (DAC) of the OECD and the Financial Tracking System of OCHA does not provide a complete insight into total humanitarian aid. More detailed analysis of available evidence suggests that humanitarian assistance is being significantly underestimated, and that in practice, real spending on humanitarian interventions is twice as high as the official figures suggest.

- However it is measured, humanitarian aid has been growing in volume and as a share of Official Development Assistance (ODA).
- When all humanitarian aid spending was added up, including funding from non-OECD donors, general public contributions to NGO’s and the cost of post-conflict peace activities, the resources for humanitarian aid work amounted to approximately $10 billion in 2001.
Indonesia

Since 1998 a series of violent conflicts have affected several provinces of Indonesia. These conflicts reflect the economic and political transition as well as underlying social, ethnic and resource-related causes. After reaching 1.3 million, the current estimate number of IDPs is 650,000.

Indonesia’s conflict-affected provinces have very different coping capacities and are in different phases of conflict and recovery. Therefore, health action must cover all aspects of emergency response and post-conflict planning and recovery. Indonesia’s Government has been dealing with the crisis with the help of the international community. However, the complexity of the conflicts requires continued humanitarian assistance.

Independence in Timor-Leste led to thousands of refugees fleeing to West Timor camps along the border. Refugees still remain with uncertain futures and poor access to health services. UN intervention to assist the refugees remains limited. WHO is working on projects from T.B. to mental health, disease surveillance and disease outbreak preparedness.

In N. Maluku the conflict caused Christians to flee to N. Sulawesi. Although this province is on the way to recovery, many of the qualified health staff have not returned. WHO provided technical support in water and sanitation, improved drug supplies and management and facilitated the return of IDP health staff. The main cause of morbidity and mortality in N. Maluku remains malaria, thus WHO focused on improving capacities for diagnosis and management of malaria.

Until last year Ambon was a continuing low-intensity, unpredictable conflict. The health system on the main island remains segregated but on other islands services are beginning to integrate. Ambon is moving slowly towards recovery but many IDP’s still live in camps supported by WHO Health as Bridge for Peace programme. Since 2001, WHO has been supporting the Health as Bridge for Peace programme in Ambon, which assists the local health authorities in working towards reintegrating the health system around the province.

The renewal of hostilities in Aceh led to displacement of around 42,000 people. Many are housed in various sites scattered in 10 districts where the violence is the heaviest. Although there appears to be no health emergency at present, 32 health facilities have been burned in different districts and in the past health workers have been targeted. The WHO office in Aceh provides technical support to monitor and plan interventions for affected communities. WHO has distributed 20 emergency health kits, worked on contingency planning, provided technical assistance for supply management systems and developing plans for a Minimum Essential Package to support the health system in responding to the crisis.

For further information please contact A. Akhtar at AkhtarA@who.or.id

Health and Humanitarian Situation in DPR Korea

During the 1960s and 1970s an extensive health infrastructure was developed in Democratic People’s Republic of Korea (DPRK), providing access to free health care throughout the country. However, in the 1990s, DPRK was faced with major economic difficulties and natural disasters that led to a massive reduction in the size of the economy.

The economic difficulties, paralleled with the diminishing capacity of the state to deliver health and social services have had a negative impact on the health and nutritional situation of the Korean people. The country has no private health sector; people therefore solely depend on the services provided by the state.

In 2003 there has been improvement of the humanitarian situation, but conditions remain fragile. Access to basic health care is still unsatisfactory with critical shortages of essential medicines and medical supplies, inadequate resources to handle complications related to childbirth, severe infections in children and surgical emergencies. The nutritional situation and food security have improved. But malaria has re-emerged.

The SARS outbreak highlighted the vulnerability of the health care system; infrastructure problems, lack of adequate water and sanitation facilities and scarcity of electricity make proper infection control in hospitals difficult. The infrastructure needs large-scale restructuring and improvements, but this will depend on the revival of the overall economy and infrastructure in the country.

The current political climate is a limitation for attracting funds, in particular for development activities. DPRK does not have access to International financial institutions such as the World Bank and Asian Development Bank. However, health must be given a higher priority and receive more resources from the government and donors to improve access to basic health services.

Extracted from the Health and Humanitarian Situation in DPR Korea - July 2003 report of the WHO country office
Forgotten refugees and other displaced populations

The recent wars in Iraq and Afghanistan have eaten up a huge amount of funds that would have been available for other emergencies such as Côte d’Ivoire, Liberia, DRC, Southern Sudan, among others. It is impossible to quantify the suffering and death this has caused. However, as clearly shown by these wars, if there is political will, sufficient funds can be made available for any endeavour.

Besides the emergencies listed above, other protracted crises seem to have been forgotten by most donors. These include, but are not limited to, the Saharawi refugees in Algeria, Bhutanese refugees in Nepal, internally displaced persons (IDPs) in Serbia and Montenegro, as well as urban refugees in South Africa.

In the case of the Saharawi refugees, insufficient funds have truly increased morbidity and presumably mortality. Conversely, in Nepal, there are sufficient funds for the Bhutanese refugees and their health is actually better than the surrounding local population. However, they suffer from diseases that are unique to their displacement and isolation in camps: micronutrient deficiencies and psychosocial distress.

All these groups face severe discrimination and hopelessness that is difficult to quantify but very real. Most Bhutanese refugees have recently lost Bhutanese citizenship and face an uncertain future. Talks between Morocco and the Polisario have gone nowhere for years, causing despair among the Saharawi. Land issues, asylum and funding.

Related to the above issue, and on another front, the failure of many agencies to act on humanitarian emergencies has led to the development of new tools to address these events. In 2002, many refugee programmes, especially in Africa, were forced to cut up to a third of their budgets, with serious consequences in their capacity to provide basic life-saving services. Further cuts are likely for 2003. These tragedies are on a second-tier in terms of political or media attention and funding.

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The LANCET, July 5, 2003

For the Saharawi refugees in Algeria, inadequate funding has led to serious intermittent shortages of food, water, and other services, provision of which often falls below minimum standards agreed for disaster response.

The LANCET, July 5, 2003

Humanitarian aid to Afghanistan, Iraq and Mano River countries

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resolution. This requires advocacy from civil society and the United Nations to pressure Governments into action.

This article was contributed by P. Spiegel and based on his article Forgotten refugees and other displaced populations. The LANCET, Vol 362, July 5, 2003

Endnotes


3 Anthropometric and micronutrient nutrition survey in Saharawi refugee camps, Tindouf, Algeria. Tindouf: UNHCR, WFP, Centre for International Child Health, 2002

4 Afrol News. Saharawi refugees “left high and dry”.


8 ibidem.


10 Commission adopts Euro 17 million humanitarian aid package for Sierra Leone, Guinea and Liberia. www.reliefweb.int/w/rwb.nlfi/c7ca0eaf6c79f9aae852567af003c69ca/a9e83dce16024a49cl11256b4904a40e8?OpenDocument (accessed June 8, 2003)

11 Afghanistan crisis - Commission allocates a further €10 million in humanitarian aid. www.reliefweb.int/w/rwb.nlfi/c7ca0eaf6c79f9aae852567af003c69ca/14153df36e7daa87585256c940067961e?OpenDocument (accessed June 8, 2003)


Human Development Report 2003

The UNDP Human Development Report 2003: Millennium Development Goals: A compact among nations to end human poverty has been published and can be downloaded or ordered from www.UNDP.org
ALL EMERGENCIES ARE COMPLEX

All emergencies are “complex”

The leitmotiv of this newsletter is that donor interests make the difference between a noisy and a silent emergency. This pattern also applies to natural disasters: floods in Mozambique in 2000 attracted more than seven times the emergency aid than the cyclone that hit Orissa a few months earlier, even if the death toll and economic losses were much higher in the latter.

Also, “complex emergency” is not a homogeneous reality. In the “new wars”, where the main motive is access to resources, the main conflict can fragment, as it occurs in Sudan, where the long war between the northern government and the southern opposition group is accompanied by so-called “second-tier” conflicts. These sub-emergencies, described in the editorial, determine in Sudan a ‘leopard-skin’ pattern, with some areas enjoying relative stability and others characterised by violence and insecurity. This put the peace negotiators in Sudan in a paradoxical situation: clinching a deal could result in splinter groups having more space and freedom for fighting. Similar, although not identical patterns, occur in Indonesia where areas of active violent conflict coexist with stable areas of economic growth. The same country can, therefore, coexist with all the spectrum of instability, as discussed in the article on transition. The extract from the UNDP Development Report of 2003 stresses the link between conflicts and poor development and points to the convergent disparities between the Human Poverty Index and Development Index and conflicts within regions and countries.

The table on CAP countries and Millenium Development Goals shows not only how far countries in crisis are from achieving the targets, but also that a lot of indicators are missing. A country without data to reflect the misery and suffering of its population and its path to the MDG is likely to remain silent. The vicious circle of lack of information and lack of aid is closed.

Endnotes

1 GR. Olsen, K Hoyen and N. Carstensen: (complete reference in the editorial, page 3)

2 conflicts between communities arising over control of local resources.

Violent conflict and the Millenium Development Goals

Surprisingly, some countries - such as Indonesia and Sri Lanka - have experienced significant conflict yet continue to make good progress towards the Millenium Development Goals. Two reasons explain these seemingly unlikely successes.

First, good policies are vital: strong governments that continue to provide services for all people can make a huge difference in human outcomes.

Second, conflicts often do not involve entire countries, but are isolated to specific regions. Thus, the impacts of war may not be reflected in national indicators - but in areas where conflict rages, its effects can still be devastating.


Conflicts within countries

Violent conflicts are often contained within certain areas of countries, driven by ethnic, linguistic and similar social fault lines.

The links between conflicts and poor development can go both ways. Economic and social hardships, especially when accompanied by sharp inequalities across groups and areas, can foment violence. At the same time, conflicts are often major causes of weak economic development, leading to (among other things) health crises and the destruction of infrastructure. This relationship can be captured by comparing the spatial distribution of conflicts with sub-national indicators of development.

Indonesia. Sharp regional disparities in the human poverty index (HPI) appear across and within the islands of Indonesia. Violent, separatist conflicts have occurred in areas with high poverty, with sharp divisions along religious, ethnic and social lines.

Colombia. Violence runs high and medium throughout the parallel mountain chains that run from the north to south of Colombia, as well as in the areas linking these mountains to the Pacific coast. The mountains are largely rural, with little infrastructure, and often inhospitable. The human development index (HDI) is lowest in some of the areas where conflict has been most violent.

Nepal. The Maoist uprising that began in Nepal in 1996 is based in the country’s most isolated, neglected and resource-poor areas, those lacking even the most basic social infrastructure. Among these are remote villages containing ethnic minorities, including low HDI areas in the northwest and some areas in the north.

UNDP Human Development Report 2003 pg 48 (UNDP 2003a)
Crises and the Millennium Development Goals

Complex emergencies are characterised by political instability, and human insecurity, associated with the limited capacity of government and other institutions to manage conflicts which results in violence, displacement, intimidation, fear, etc. The international community is expected to take exceptional action in these situations, and for WHO one challenge is to help our partners reflect on the growing importance of these situations within the context of Millennium Development Goals and other international development targets. At least 23% of people in Africa are living in complex emergencies. WHO’s focus on scaling up the international response to global health inequities and risks to health calls for us to play our part in Exceptional Action for Health in Crises that is needed in complex emergencies.

When the Director General deems that exceptional action is needed, the whole of the organisation will mobilise around an agreed “umbrella” strategy. This will include: a clear goal, objectives, activities, milestones and a plan for appropriate resource inputs.

Excerpt from a speech by D. Nabarro during the WHO Meeting for Interested Parties, October 2002

The Millennium Development Goals can be accessed at: www.developmentgoals.org

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... lack of information is the most reliable indicator of vulnerability

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Goal 1 Eradicate extreme poverty and hunger
Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day

Goal 2 Achieve universal primary education
Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Goal 3 Promote gender equality and empower women
Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015

Goal 4 Reduce child mortality
Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Goal 5 Improve maternal health
Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Goal 6 Combat HIV/AIDS, malaria, and other diseases
Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Goal 7 Ensure environmental sustainability
Halve, by 2015, the proportion of people without sustainable access to safe drinking water
Transition

Fundamental to the concept of transition “from relief to development” or from conflict to peace is that these very processes are neither unilinear nor unidirectional. Rather, the various facets of transition coexist simultaneously at changing levels of intensity, susceptibility to reversals, and opportunity. Transition is, by definition, dynamic and often unpredictable.

Transition includes situations where:

- Conflict is no longer raging or has subsided, but peace is not yet consolidated or is fragile. In essence, as defined by the IASC, a situation of “no war and no peace,” where tensions are such that “matters could get worse before they get better.”
- Instability persists and a relapse into violence remains a real possibility, especially where regional or global influences are at work, when groups or parties to conflict remain dissatisfied with the terms which ended the violence or when a ceasefire has been reached but a peace agreement is still being negotiated or the peace is fragile.
- Humanitarian action needs to continue or be expanded into newly accessible areas, where a peace operation may or may not be mandated/present, and where development pre-investments are required. The interdependence of these types of interventions needs to cohere, with peacebuilding objectives underpinning that coherence.
- Transition may not necessarily be the same as recovery; rather, it refers to those efforts needed to sustain the peace process and allow its consolidation, thereby setting the stage for recovery.
- Transition often includes specific and critical issues that are time-bound, require rapid response and regular review.
- Operational response capacity has to be flexible and be able to simultaneously address relief, recovery and development needs, create conditions which are conducive to the return of displaced populations and help to stabilize the situation.
- Government capacity to set priorities for recovery and longer-term development and to lead the planning process needs to be determined, as it influences the relative emphases of the UN country teams on capacity building, aid management and coordination, etc.
- An immediate and increased level of donor funding to enable the UN Country Team to effectively respond to the transition is needed; so too an increased flexibility in the allocation of those funds among humanitarian, recovery and development interventions as conditions or opportunities dictate.
- A regional or sub-regional scope may be pertinent for planning, particularly in respect of Disarmament, Demobilisation and Reintegration (DDR).
- Transition strategies need to be horizontally integrated (whether simultaneous or sequential), quick-acting, and yield tangible results.
- Transition priorities need to reflect coordinated and coherent plans, participation of local stakeholders and monitoring objectives. They need to focus on stability, structural reforms, bottom-up programming based on shared vision with local actors, confidence building and capacity building.

For further information please contact A. Loretti at: lorettia@who.int

Endnotes

1 “Guidelines for Field Staff for Promoting Reintegration in Transition Situations” IASC Reference Group on Post-Conflict Transition, 2001, page 1
WHO programme for communicable diseases in complex emergencies

The goal of the Communicable Diseases in Complex Emergencies programme is to reduce the high excess mortality and morbidity due to communicable diseases in populations affected by complex emergencies - defined as situations of war or civil strife affecting large civilian populations.

The priority complex emergency countries targeted include: Angola, Democratic Republic of Congo, Liberia, Sierra Leone, Afghanistan, Somalia, Southern Sudan and Iraq. The Communicable Disease Working Group on Emergencies (CD-WGE) is implementing programme activities including: development of standards, guidelines and new tools, technical and operational support on communicable disease control to priority countries and training on communicable disease surveillance and control. The working group is comprised of communicable disease control experts throughout WHO - Geneva, providing coordinated technical support to EHA, regional and country offices and partners. Its areas of expertise include surveillance, outbreak preparedness and response, TB, malaria, HIV/AIDS, diarrhoeal disease control, immunisation, child health and lab services. The communicable disease task force for Iraq was set up in January 2003 as part of the CD-WGE.

For further information please contact M. Connolly at connollym@who.int

Virtual Health Library for Disasters 2003

The Virtual Health Library for Disasters (HELID) 2003 edition has been released. It is the most complete information resource on public health for disasters and complex emergencies reduction. HELID is a collection of more than 500 full text technical guidelines selected for their relevance and quality.

The features include:

- Availability of publications on a wide variety of topics (e.g. disaster mitigation, communicable diseases, supply management and essential drugs, mental health, etc.)
- A powerful and easy-to-use search engine to locate information by topic, title and key word.
- The option to download the complete collection to a hard drive or to download individual publications.
- Available on CD-ROM and the Internet
- All documents available in HTML and most in PDF format

For more information, contact WHO at cha@who.int or PAHO at disaster-publications@paho.org. Visit this collection on the Internet: www.helid.desastres.net