Roll Back Malaria (RBM) is a global initiative to reduce death and suffering from malaria by 50% by 2010. Nowhere is the need for action more acute than in complex emergencies.

The last decade has witnessed a significant increase in both the numbers of conflict-based emergencies and natural disasters across every continent of the world. The majority of these complex emergencies have occurred in malaria endemic areas and many have continued for years unresolved. More complex emergencies have occurred within Africa than any other continent during this period. Today over 180 million people in Africa are living in countries affected by conflict, where infrastructure breakdown, population displacement, poverty, poor access to basic health care and food supplies, are the norm. War-affected communities often live in appalling conditions for years and are amongst the most vulnerable in the world to disease and starvation.

Tragically, 86% of all annual global deaths from malaria occur in Africa where the deadly Plasmodium falciparum strain of malaria predominates. Of the 960,000 estimated annual deaths in Africa WHO estimates at least 30% occur in countries affected by conflict. Malaria is often the main cause of ill health and death in emergencies.

Some groups are particularly vulnerable, especially in the acute phase of a complex emergency, because they are given less priority in distribution of limited resources or have greater difficulty in accessing treatment and care. Depending on the situation, these may include minority ethnic groups, older people, people with disabilities, and infants and children who are already weak or sick.

The Challenge

To halve malaria deaths and reduce suffering in these complex circumstances demand new and dynamic approaches – current approaches aren’t doing the job. However, many of the necessary approaches to the problem are already in place:

√ a committed and focused partnership of national and international organisations, including the UN, governments, donors, NGOs and faith based organisations working together with the affected communities;

√ appropriate tools with which to work and good technical direction and backup. As the secretariat of the global partnership, the technical resources that WHO can bring to this initiative, both internally and through it’s wide ranging network of partners, is potentially enormous;

√ cost-effective treatments already available for malaria. New artemisinine based combinations of anti-malaria drugs are available for less than $3 US per treatment, and some of the cheapest drugs, where still efficacious, cost as little as 10 cents per treatment. Family size impregnated bed nets can be purchased in bulk for as little as $2.50 each.

There are at least two remaining challenges to achieving RBM’s goals. The first is to ensure that the RBM partners with key roles assume their responsibilities and use the tools available to them to control malaria in complex emergencies. This is particularly important for WHO, because taking its leadership role in the partnership to Roll Back Malaria in complex emergencies will require the Organization to work in new and innovative ways. For RBM to succeed in emergency situations, WHO will need to proactively forge new dynamic and effective partnerships with NGOs, faith based organisations, affected communities as well as national authorities in each complex emergency. Well supported cross-sectoral country partnerships are the key to success.

The second main challenge is the development of new tools to use in efforts to control malaria in complex emergencies, and to make these widely available at the field level. RBM is currently supporting the development and evaluation of insecticide impregnated emergency shelter materials, new drug combinations particularly suited to emergencies, a field handbook, a data base on complex emergency countries and emergency training resources.

The challenges are enormous. It is imperative that we seize the new opportunity which the global support for RBM now provides. The rapidly growing partnerships in complex emergencies together with both existing and new tools under development provide a better opportunity than we have had for reducing death and suffering even in the most complex of situations.

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Strategies to Tackle Emergencies

RBM is tackling both chronic emergencies - such as in DR Congo and Sierra Leone - and new emergencies in order to reduce the toll of malaria in these countries. In recognition that these different types of complex emergencies require different approaches, RBM has developed two different strategies for interventions.

RBM is taking a two-pronged strategic approach to rolling back malaria in chronic emergency countries. The first prong of this approach calls for assessing the situation and determining the capacity in-country to respond to the assessed needs. What is needed for scaling up response to meet demands is also ascertained. The second prong of the strategy is to provide full-time RBM partnership support officers in country. They will provide daily support to partner organisations by assisting their RBM assessment, advocacy, planning, implementation and monitoring activities and will receive specific, short-term support of the Technical Support Network (TSN) on complex emergencies as needed. This will be piloted in DR Congo with two RBM partnership support officers, one in Kinshasa and one in Goma. Three other priority countries will receive similar support in 2001.

New emergencies require a slightly different approach comprised of two parts. Short-term technical support will be rapidly mobilised to support countries through RBM’s secretariat and it’s TSN. This is a network of partners that can provide short-term technical assistance to countries on an ad hoc basis. In addition, a number of new tools are being developed to improve the efficacy of efforts to control malaria (see article on page 4 for more information on these new tools). The same strategy can be applied to countries outside of those targeted in chronic emergencies.

Treatment options in Burundi

Preliminary results of a six-site study on the efficacy of antimalarial drugs in Burundi show frighteningly high levels of resistance to national first- and second-line antimalarials for the treatment of uncomplicated malaria. The study, conducted in partnership between MOH, WHO and NGOs supported by RBM Technical Support Network for Complex Emergencies, suggest levels of Plasmodium falciparum resistance to chloroquine (CQ) higher than 80% and sulphadoxine-pyrimethamine (SP) as high as 50% in the worst affected areas.

Burundi is slowly emerging from the largest malaria epidemic in its history. RBM partners moved quickly to change the first line treatment in epidemic affected areas in November 2000. But now, the challenge is to find an alternative and more effective treatment in the face of resistance for areas where case loads continue to be as high as 16,000 per week. Artemesinin-based combination therapy is likely to be the way forward, but with resistance to SP alternative candidate drugs will need to be considered for use in combination with artesunate.

There were many challenges in responding to the epidemic. Ongoing insecurity limited access to treatment in many affected areas, logistical constraints limited the scope and timeliness of indoor residual spraying and limitations to surveillance data mean that accurate data, particularly mortality data, were not available for targeting of responses. High levels of resistance to antimalarials and patchy following of drug treatment protocols contributed to ongoing morbidity and mortality.

A rapid increase in malaria cases in the third week of October 2000 marked the beginning of what was to be the largest epidemic in Burundi’s history. By the end of January 2001, more than 2,000,000 people were reported to have been affected. The majority of cases were from 7 of the country’s 17 provinces, at an altitude of 1400-1800 metres. These highland areas were formerly considered non-malarious. Over the last 10 years highland malaria incidence has gradually increased, coinciding with increased exploitation of marshlands for agriculture.

The Ministry of Health, NGOs, WHO, bilateral organisations and other UN bodies together responded promptly to increase access to antimalarial treatment, initiate indoor residual spraying campaigns, and distribute bednets in the most affected areas.

The ongoing malaria epidemic in Burundi is yet another infectious disease outbreak for a country racked by 8 years of civil war. The year 2000 had already seen outbreaks of measles and typhoid, and the malaria epidemic was quickly followed by a cholera outbreak in the midst of escalating insecurity. The prompt response from partners to the malaria epidemic demonstrates that it is possible to act effectively in a setting constrained by poverty, insecurity and infrastructural breakdown. The challenge now for partners is to collaborate for better prevention and more effective malaria treatments.

WHAT IS RBM?

Roll Back Malaria ( RBM) is a global partnership launched on behalf of WHO, UNICEF, World Bank, UNDP by the Director General of WHO, Dr Gro Harlem Brundtland, in October 1998. It was evident that malaria was both a top political priority among African leaders and that it was still a major health scourge in many parts of the world, in Africa above all.

The goal of the global partnership, which includes governments of endemic countries, the international donor community, NGOs, faith-based organisations, the private sector including commercial enterprises, academic institutions, UN organisations and affected communities, has set a goal of halving deaths from malaria by 2010.

For further information, please contact R Allan at allanr@who.int
Malaria in a natural disaster

The RBM initiative has been implemented in Bolivia with the following objectives:

1) reduce the proportional prevalence of infection with *Plasmodium falciparum* from 25% to 1%,
2) reduce the mortality rate of malaria from *P. falciparum* from 4.5 to 0.2 per 100,000 inhabitants and
3) reduce the annual parasitic incidence from 28.4 to 5 per 1,000 exposed population in the period 2000 - 2004.1

It is estimated that 75% of Bolivia is a malaria transmission zone, particularly in the “rainy” oriental zone (Amazon region), an area with high precipitation.2

Bolivia is faced with natural disasters as a result of an increase in precipitation. In the month of January of 2001 the increase was approximately 40% in the high Andean zone and 28% in the humid areas of the oriental region compared with the average of the last 30 years.3

The bio-physical characteristics of the Bolivian terrain and the increase in precipitation resulted in an increase in the volume and a change in the course of the rivers whose origin is in the Amazon region. The period immediately after the flooding did not generate conditions favouring vector reproduction in most parts of the country. However, in the “rainy” oriental zone the increase in precipitation immediately generated favourable conditions for vector reproduction.

In the first 5 epidemiological weeks 2001, 43 malaria cases of *P. falciparum* and 1,582 of *P. vivax* were reported, in comparison to 145 and 2,342 respectively in the same period in the year 2000. In all nine departments of the country, the number of *P. falciparum* malaria cases was less in January 2001 as compared to the previous year. The exception was in the Pando department - located in the humid oriental zone, where the precipitation increased with 28% - where there was a significant increase (approximately 30%) of *P. vivax* malaria cases.4

For further information, please contact Dr. José Antonio Pagés, Representante de OPS/OMS en Bolivia, japages@bol.ops-oms.org

1 RBM en la región de la selva tropical de América del Sur, Reunión de Lima, octubre de 1999, citado en Gil E., Paludismo en Países Amazónicos, Serie Documentos Técnicos, OPS, Bolivia 2000
2 Ministerio de Salud y Previsión Social, La Malaria en Bolivia, Publicación Técnica Nº 3, 2000
3 Servicio Nacional de Hidrometeorología
4 Notificación Semanal, Dirección General de Epidemiología, Ministerio de Salud, Bolivia 2001

Country profiles, RBM’s newsletter, technical guidance and more are available on Roll Back Malaria’s Website at: www.rbm.who.int

Special Efforts for Emergencies

Malaria is a major health problem in countries affected by complex emergencies (emergencies created normally through conflict or political upheaval/persecution); in these circumstance malaria may account for 50-90% of all outpatient consultations and over 50% of mortality. Multiple factors may contribute to increasing the vulnerability of affected populations to malaria. These may include the breakdown of health care services resulting in poor access to effective treatment, displacement of communities from areas of low (or no) malaria transmission to areas where there is higher transmission of malaria. Malnutrition, lack of basic shelter and multiple infections may also increase the vulnerability of populations to malaria.

Over the last decade, there have been a number of developments in the prevention, diagnosis and treatment of malaria. For example, insecticide-treated bednets can reduce mortality from malaria by 20% or more. New easy-to-use tools make diagnosis more accurate and the development of new therapies - particularly artemether based combinations - may delay the development of resistance.

However, many of the strategies used to control malaria in stable situations are often not suited to complex emergencies and so must be adapted to fit the conditions. UN, Red Cross and non-governmental organisations normally provide additional support to local populations, NGOs, church organisations and other partners during emergencies to ensure the provision of basic health care to the most vulnerable under these circumstances. However, many of the international and local emergency health partners have little technical expertise or experience with controlling malaria, or preventing and responding to epidemics in this context.

Through RBM in Complex Emergencies, tools and response capacity have been developing and improving since 1998. Never before have the technical and partnership opportunities for rolling back malaria been so great, particularly in Africa. Now is the time to capitalise on these newly created opportunities and make a real difference for some of the most vulnerable populations in the world.

For further information, please contact R. Allan at allanr@who.int

Taking the Partnership to Scale

How can malaria-affected countries and their partners mobilize action beyond malaria control programs, beyond the public health sector, and beyond the public sector? This will be the topic of the 4th Meeting of the Global Partnership to Roll Back Malaria, to be held in April 2001.

If the RBM partnership is to achieve its stated targets then we must greatly increase the volume of actors and actions at country level. This meeting will determine how to build on the success of the past three years and expand the capacity of the RBM Partnership to scale.

Further information is available at www.rbm.who.int or email rbmmeeting@worldbank.org
New Tools to Roll Back Malaria

A number of new tools are being developed to improve response capacity.

√ Inter-agency handbook for malaria control in complex emergencies: UNHCR and the Roll Back Malaria Secretariat identified the need for comprehensive guidelines for emergency health teams who need to establish effective malaria control interventions in emergency settings. The handbook has been written by malaria experts with relevant field experience from the RBM Technical Support Network (TSN) to enable any health care agency to deal adequately with malaria problems in such conditions.

There are several texts on malaria control in stable environments, but none that specifically address the operational or technical problems of complex emergencies, or of the non-specialist health care agencies that operate in these situations. This handbook aims to reinforce partners’ capacity to assess the malaria situation, design effective responses, including identifying and implementing essential operational research as needed. The handbook will be available mid-2001.

√ Information tools: RBM’s website (www.rbm.who.int) has been developed to facilitate country partnerships and foster two-way information exchange. Sections of the site are devoted to operational research, country progress and complex emergencies. Malaria-specific country profiles are also being developed to assist NGOs, UN agencies and governments with assessments and to improve access to essential information. Profiles for many countries are available through key web sites, including the RBM web site and WHO Emergencies site (www.who.int/eha/disasters) to increase accessibility for partners. Country information is being added as it becomes available.

√ Field training course: RBM field partners urgently require effective and well targeted training at the field level to increase their technical capacity. The proposed 7-day course is designed to build capacity of RBM partner field teams to assess malaria in complex emergencies, to develop and implement emergency malaria control programmes and to monitor and evaluate the impact of interventions, utilising the guidelines and resources developed by RBM. The course will also prepare participants to plan and conduct training activities for different categories of staff with the assistance of teaching materials provided. Field-based training will be essential to maximise the standardised use of RBM guidelines, information resources, new tools and technical support that will be provided to partners in complex emergencies over the coming months and years. The RBM secretariat, TSN and key units within WHO, in partnership with experienced NGOs, are able to develop and deliver an effective training package. Through this vital combined package of support, both the technical capacity of RBM partners and the scale of the overall RBM response in complex emergencies will be significantly increased.

√ New insecticide-treated materials: Implementing partners currently have a limited range of tools for malaria prevention, including residual spraying and insecticide treated bed nets. Both of these tools were developed for stable environments and have major logistical and operational constraints that greatly restrict their use in acute phase emergencies, especially amongst displaced populations. New tools are being developed to control malaria and other life threatening vector borne diseases. These tools need to be effective, affordable and ready to use in the early stages of emergencies. Potentially effective new tools now under development with support from US Department of State Bureau of Population, Refugees and Migration include:

- Insecticide treated plastic and canvas sheeting, for use as emergency shelter material (using UNHCR standard construction specifications); and
- Insecticide treated blankets.

These will become available in 2002.

For further information, please contact R. Allan at allanr@who.int

Information on RBM

RBM has developed a number of ways to disseminate its information on malaria in complex emergencies. Two of these are the RBM website and the newsletter. RBM’s website (http://www.rbm.who.int/) has been designed to disseminate information to a wide audience. There is a specific section devoted to RBM in complex emergencies, where you can access country profiles, information on operational issues and up-to-date information on current outbreaks. RBM News is published on a quarterly basis and highlights new initiatives and developments in the RBM partnership. The newsletter is available by request to rbmnews@who.int or on the website.

Malaria - Technical Details

Symptoms of malaria include fever, shivering, pain in the joints, headache, repeated vomiting, generalized convulsions and coma. Severe anaemia (exacerbated by malaria) is often the attributable cause of death in areas with intense malaria transmission. If not treated, the disease, particularly that caused by *P. falciparum*, progresses to severe malaria. Severe malaria is associated with death.

Malaria is transmitted by Anopheles mosquitoes, the number and type of which determine the extent of transmission in a given area. Transmission of malaria is affected by climate and geography, and often coincides with the rainy season.

Perhaps more than any other disease, malaria hits the poor. Malaria endemic countries are some of the world’s poorest. Costs to countries include costs for control and lost workdays - estimated to be 1-5% of GPD in Africa. For the individual, costs include the price of treatment and prevention, and lost income.

Fact Sheet No 94 - Malaria, Revised October 1998
Malaria Control in Solomon Islands

A successful malaria control programme in the Solomon Islands, which has led to a steady reduction in cases of malaria since 1992, has suffered some setbacks due to conflict and economic difficulties. However, remedial action, including increased staff, indoor spraying and free bednets, has reversed the trend. The economic crisis faced by the Government and lack of law and order is the only impediment for future success.

There had been a steady reduction in cases of malaria since 1992 when a workable and sustainable program for malaria control was established (fig 1). An intensified malaria control program in the capital Honiara launched by WHO in 1995 has reduced the incidence by 82%. Deaths due to malaria have also declined by 50% since 1995.

A two-year ethnic conflict, which erupted in 1998 between two indigenous island groups in Solomon Islands, has caused serious economic, social and political disruptions in the country. The Townsville Peace Agreement was signed on 15 October 2000, but the restoration of normalcy continues to be plagued by various factors. The economic impact of the current crisis is devastating - the annual revenue for the country has decreased from USD 79 million to 55 million in 2000 and is projected to decline to 38 million this year. All major health programmes are affected all over the country.

As a result, the malaria control programme has suffered some major setbacks. Diagnostic facilities have temporarily closed in several parts of Honiara and Guadalcanal. Low staff morale, lack of funds and delay in the implementation of control measures are the main factors hampering the program. Malaria mortality has also increased in these provinces. Preliminary data from the paediatric ward of the national referral hospital in Honiara clearly shows an increase in the percentage of malaria admissions from 10.7% in 1998, 15.7% in 1999 and 22.5% in 2000.

Stable malaria endemicity is maintained over a wide range of transmission intensities in Solomon Islands. The internally displaced people with higher parasitemia (> 20% prevalence rate) were displaced to regions with moderate transmission intensities (prevalence rate ~8%). This has resulted in an increase in the number of cerebral malaria cases within the population.

WHO with other donor partners implemented several measures to curb the increase in the number of cases.

- Diagnostic services were restored in several clinics with the provision of rapid diagnostic test kits and several workshops were organized for nursing staff to guide them on the management of severe cases.
- Adequate staff was made available to carry out control measures among the internally displaced people, including epidemiological case monitoring officers. Staff were reassigned so that people of the same ethnic group carried out the programme in their provinces.
- Indoor residual spraying of houses was carried out in accessible areas and over 50,000 people were protected by this measure along with the provision of insecticide treated nets.
- Free nets were distributed to pregnant women and mothers with infants through the international Red Cross and community contribution for the nets were lowered to make it more affordable. The judicious use of a revolving fund helped to overcome a lack of funds.
- The surveillance programme in the capital is also being restored in a phased manner.

For further information, please contact R. Velayudhan at velayudhanr@fij.wpro.who.int

World’s Malaria Burden

- Every two minutes, three children die of malaria, with the majority of them in sub Saharan African countries.
- One third of the African population is living in complex emergency situations.
- One fifth of the World’s population is at risk: poorest people are most vulnerable.
- 300-500 million clinical cases per year, with over 86% of cases in Africa.
- More than 1 million deaths per year, over 86% of which in Africa.
- Major impact on human and economic development, $12 billion lost annually.

For further information, please contact R. Allan at allanr@who.int

New Treatment For Malaria

GlaxoSmithKline is linking up with the World Health Organisation to develop a malaria treatment to be sold cheaply to poor countries in Africa. The new treatment, Lapdap, is made from existing anti-malaria drugs and is effective against strains of the mosquito-borne disease resistant to current remedies. The treatment will be available in some countries next year. A joint team from the WHO and Glaxo is overseeing the project which is funded in part by Britain’s Department for International Development.

Lessons Learned in Emergencies

In the global meeting of all WHO’s Country Representatives (WRs) and Country Liaison Officers, one session was devoted to sharing lessons learned in emergencies at the country level. The subject had been included in the agenda of the Global Meeting at the request of WRs. In 2000, seven out of 10 WRs asked to submit case studies for an internal management development programme, focused their reply on emergencies. The WRs looked at the lessons they and their peers have learned at field level, elaborated how best to prepare for future emergencies and concluded the following:

√ Vulnerability to disasters and emergency management, as core concerns of WHO, demand a Public Health Approach.

√ WHO has precise responsibilities and unique assets in building national capacities for disaster reduction, from prevention to humanitarian response and early rehabilitation.

√ WHO must assume a more active role in mobilising and coordinating resources for public health in disaster reduction and humanitarian action.

√ There is agreement on the usefulness and feasibility at country level of the proposed WHO’s Core Commitments in Emergencies.

For further information, please contact A. Loretti at lorettaa@who.int

Evaluating WHO in Emergencies

WHO has a responsibility to monitor and analyse its own performance as well as the health impact of humanitarian efforts. The Organization is taking this responsibility seriously by implementing a series of programme evaluations during 2001. Evaluation helps decision making, technical quality control and accountability. Therefore, WHO works at strengthening and integrating evaluation as a regular feature of its program management. An external review of the WHO emergency programmes in the Democratic People’s Republic of Korea was carried out in September and October last year in cooperation with SIDA. This year, an extensive evaluation of the WHO program in Iraq has taken place in March and internal evaluations of WHO programmes in East Timor and Kosovo are planned.

In addition, WHO is developing approaches to evaluate, in a wider context, the health outcomes of emergency operations. These efforts will include facilitating joint evaluations with other partners, as well as introducing a learning function during the relief phase. By developing and integrating this function in its coordination role, WHO will enhance the effectiveness and coherence of all disaster response programmes.

For further information, please contact A Griekspoor at griekspoor@who.int

End of Ebola Outbreak in Uganda

Global health security will be a top item at this year’s World Health Assembly. The Uganda Ebola haemorrhagic fever (EHF) outbreak emphasizes the need for a global system to verify epidemic intelligence and coordinate international response to outbreaks that threaten national and global health security. The Global Outbreak Alert and Response Network is the key technical partnership in surveillance and response to combat epidemics rapidly.

World Health Organization (WHO) coordinated international support from the Global Outbreak Alert and Response Network to Uganda to contain the viral disease that killed 224 people in Uganda. Before the disease was identified as EHF, Uganda facilitated rapid access for WHO, and the Global Outbreak Alert and Response Network responded with technical experts, protective equipment and logistics support.

More than 25 organizations and over 100 international staff worked together to combat the outbreak. The Centers for Disease Control and Prevention (CDC), Epicentre, Health Canada, Italian Cooperation, Médecins sans Frontières (MSF), the Red Cross and UNICEF, together with institutions in Belgium, Germany, Italy, Japan and the United Kingdom worked closely with the doctors, nurses and staff at Gulu and St. Mary’s (Lacor) hospitals, where a field laboratory was maintained by CDC throughout the outbreak.

Remarkable community solidarity involved the entire Gulu community in fighting EHF: hundreds joined surveillance teams and worked together to raise awareness of how Ebola is spread and how to avoid infection.

WHO is ensuring that outbreak response reduces future vulnerability to epidemic-prone diseases. In partnership with Italian Cooperation, CDC, Public Health Laboratories Services, UK and the Ministry of Health, an early-warning surveillance system for epidemic-prone diseases, based on local structures and capacities, is being set up in Gulu District.

Financial support was provided by Canada, the European Commission (ECHO), Germany, Ireland, Norway, the Netherlands and Japan.

For further information, please contact M Ryan at ryanm@who.int or K O’ Bai Kamara at kandebure@who.int

EHA has revamped its website. The redesigned site focuses on providing information on what is happening in emergency situations (health situation reports, epidemiological surveillance, needs assessments etc.) and what to do about it (technical guidance).

Visit the site at: http://www.who.int/eha/disasters/
Rapid Response to Gujarat Quake

After the recent earthquake in Gujarat, WHO immediately mobilized their regional focal point for emergencies to conduct rapid health assessments, thereby providing necessary information to mount an effective response within hours of the disaster.

On 26 January an earthquake measuring approximately 6.9 on the Richter scale hit Gujarat State in Northwest India. The health system facilities and health infrastructure were severely damaged. The routine immunization activities were interrupted, the sanitation conditions were inadequate and the shelter needs were extensive.

WHO’s response organized itself in two main sites, Ahmedabad and Bhuj, which were set up within 36 hours after the earthquake. The activities included rapid assessment of disaster affected areas with the medical officers of the existing local polio surveillance teams, mobilization of staff from the India, Indonesia and Nepal country offices and from the regional offices for South East Asia and the Americas and health sector coordination. Technical assistance was provided to the national health authorities in re-establishing and rehabilitation of health services and in the disaster response. An information system was set up for collation and presentation of the data reported through the post-disaster syndromic surveillance system.

Water and sanitation are one of the key issues in the prevention of outbreaks of diseases and epidemics. The health authorities had requested WHO to assist in re-establishing water quality control and provide technical advisory capacity on environmental health, and water and sanitation in the worst affected areas. In collaboration with local NGOs, mental health support and preventive health care activities are being implemented.

For further information, please contact J Larusdottir at larusdottirj@who.int

DOTS - TB Cure for All

Dr Gro Harlem Brundtland, Director General of WHO, called for equitable access to TB services for anyone with TB. During a conference for World TB Day 2001, observed on 24 March, Dr Brundtland stated ‘We have heard Ministers agree that no one should be denied access to DOTS. This means that DOTS should be available to all those who need it, wherever they live, whether they are young or old, man or woman, homeless or housed, jailed or free.’

This year’s campaign, ‘DOTS-TB cure for All’, has two main objectives: 1) to mobilize political leaders and decision-makers around the world about the situation of TB suffers, the implications of TB for human development, and the fact that there is no excuse for inaction in the face of an available, cost-effective cure and; 2) to raise awareness that a cure for TB is available and that accessing and the fact that there is no excuse for inaction in the face of the highest attainable standard of health and well-being.

Adapted from World TB Day Brief, available at http://www.stoptbworld.tb.day/WTBD_2001/Brief.access.html

Psycho-social Aspects of Disasters

WHO intends to intensify action to address the psycho-social impact of disaster reduction and humanitarian assistance on affected populations. WHO recognizes human dignity as a pre-condition of the well being and sometimes of the very survival of affected individuals and communities during emergencies.

To this end, WHO has integrated an UNHCR-seconded expert, Ms Mary Petevi, in the Department of Emergency and Humanitarian Action (EHA) who will act as focal point for all psychosocial aspects of disaster reduction and humanitarian assistance.

All programme activities will be implemented through collaboration within and around WHO and will cover a vast range of topics. Activities will include consensus building for policy development, preparation of technical guidelines and capacity building, research and consolidation of field and institutional knowledge, and assistance to member countries and partners for projects addressing the psychosocial aspects of preparedness and response.

For details, contact Ms Mary Petevi at petevim@who.ch or visit our website at http://www.who.int/eha/disasters/

Health Alert in Afghanistan

According to a joint WHO/UNICEF assessment, the situation of IDPs in Baghlan and Kunduz Provinces in north-east Afghanistan is alarming and conditions in the six displaced camps surrounding Herat, in west Afghanistan, are appalling due to freezing temperatures and overcrowding. At least 20 refugees, most of them children, are reported to die per week due to the extreme conditions.

Health agencies and NGOs are coordinating assistance efforts and providing food, shelter, water, sanitation and health services in the area. The UN has renewed its plea for support to the severely under-funded appeal, warning that the Afghan people are «at the edge of an abyss», both in country and in refugee camps in Pakistan. WHO in Afghanistan focuses its activities on essential medical supplies and training on the use of drugs, epidemic preparedness and response, promotion of safe motherhood, particularly in areas of refugee returns, rehabilitation of the water supply system, tuberculosis, malaria and leishmaniasis control, development of medical human resources, the expanded programme on immunization. In-kind contributions received since December last year from Norway and Italy have helped alleviate the suffering of the population, but US$ 4.14 million are still required for this year. On a positive note, WHO, UNICEF and the Regional Department of the Expanded Programme on Immunization have just completed a synchronized polio immunization campaign in five districts bordering Pakistan.

For further information, please contact K Shibib at shibibk@who.ch

April 7 : World Health Day 2001 is a global advocacy activity dedicated to mental health issues.

Dare to Care

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For further information, please contact K Shibib at shibibk@who.ch
Stop Propagating Disaster Myths

The international response to the tragic earthquakes in El Salvador and India highlights the need to reassess many of the myths and realities surrounding disasters, and to find ways to stop these destructive tales. The myth that things go back to normal within a few weeks is especially pernicious. The truth is that the effects of a disaster such as the El Salvador earthquake last a long time. Disaster-affected countries deplete many of their financial and material resources in the immediate post-impact phase. The bulk of the need for external assistance in El Salvador and other countries is in the restoration of normal primary health care services, water systems, housing, and income producing work. Social and mental health problems appear when the acute crisis has subsided and the victims feel (and often are) abandoned to their own means. Successful relief programs gear their operations to the fact that international interest wanes as the headlines fade, and needs and shortages become more pressing.

Pan American Health Organization Director Dr. George Alleyne, in a visit to El Salvador after the earthquake, said, «My message is that it is necessary to sustain interest in reconstruction of the country and not to forget El Salvador after the emergency stage finishes. There are going to be major needs in the medium and long term, and I want to see if we can strengthen the resources directed to the country in its new situation. The needs of El Salvador are so vast that what we can offer in financial terms is only a drop in the bucket, but we can help prepare projects for the social sector, and continue to work at local level to support the recovery and reconstruction.»

«My fear is that when the humanitarian aspect recedes people will forget the large needs that El Salvador will have for a long, long time», Dr. Alleyne added.

Donors need to be educated just as we need to educate potential victims of disasters. A little preparedness can go a long way toward alleviating the “secondary” disasters often visited on countries. Increased funding for disaster preparedness and prevention in the third world and more funding from other bilateral or international agencies could help matters.

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If donors would commit now to strengthen the local capacity to respond to future disasters in the disaster prone countries of the Americas, and other places, and learn what is important and what is futile in helping countries, the world would be better off.

It is essential that the press and the donor community be aware of what is good practice and malpractice in public health emergency management. Past sudden impact natural disasters in the Americas and elsewhere have shown the need for international contributions in cash and not in kind. This ensures that allocation of resources is field-driven by evidence of what is needed on-site. The people of El Salvador, want, as do any victims of disasters, to rebuild safer houses, have their “normal” health problems attended at the health center, put their kids in school and get back with their lives. Unilateral contributions of unrequested goods are inappropriate, burdensome, and divert resources from what is needed most.

Disaster-stricken countries appreciate external assistance that can do a lot of good when directed to real problems. Unfortunately, too much of the assistance is directed to non-issues or myths.


Displacement from Floods in Mozambique

A recent assessment in the flood-affected areas of Marromeu district, Sofala province and Chinde district, Zambezia province revealed a grave situation due to a sharp increase in the number of people entering in the accommodation centers and straining the capacity of the existing facilities. A rapid nutrition assessment, carried out on children under five, confirmed the negative effects of the current crisis. Wasting, defined by arm circumference, was detected in over 30% of the children.

According to assessments, it is particularly important to improve the sanitary situation (latrines, safe water and waste disposal), provide preventive (vaccine campaign in the centers, IEC and malaria prevention) and curative health care, including drugs provision, access to health facilities. Supplementary food is needed for the vulnerable groups, children under 5, pregnant and breast feeding women.

Finally the national, provincial and district health authorities need technical advice, support, and guidance through the presence of international agencies in the health sector for the emergency situation.

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Guinea Faces Mounting Threats

Threats to the health and well-being of refugees and local populations in the south east of Guinea presented by renewed heavy fighting and mass displacement are being compounded by the potential for outbreaks of meningitis and other transmissible diseases such as dysentery and malaria.

In mid March the UNHCR medical team reported three cases of meningitis in the newly established refugee camp of Kountaya and immediately enhanced surveillance mechanisms and set up investigation, treatment and prevention activities in collaboration with the local health authorities, partner agencies and NGOs. A yellow fever outbreak is now coming under control, but health workers remain on high alert.

At the same time, health workers are working hard to control ongoing measles outbreaks across the refugee, displaced and host populations with UNICEF-supported vaccination activities, to anticipate the impact of population movements on the ongoing yellow fever epidemic, and to reduce the potential for outbreaks of insect and water-borne disease linked to the coming rainy season.

The crisis in this part of Guinea escalated last year when refugees and Guineans living close to the borders were either cut off or forced out by multi-party conflict between the neighbouring countries of Guinea, Liberia and Sierra Leone. Violence rose again in February with heavy fighting around the town of Guéckédou.

Moves to relocate refugees away from the border have been complicated by insecurity and spontaneous flight from camps. However, UNHCR and its partner agencies had managed by end March to convey over 40,000 refugees to new camps away from the conflict zones. Some 150,000 Guineans are thought to have been displaced into communities further north.

International health NGOs such as Médecins Sans Frontières, the American Refugee Committee, Médecins du Monde together with the Guinean Red Cross and local health workers are providing health care for the new camps. They are also responding with mobile clinics and support to local health posts in areas where people are on the move, including in the infamous Parrot’s Beak, where many of the estimated 140,000 refugees have fled either cut off or forced out by multi-party conflict between the neighbouring countries of Guinea, Liberia and Sierra Leone. Violence rose again in February with heavy fighting around the town of Guéckédou.

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Depleted Uranium No Health Threat

Based on observations in Kosovo, supplemented with international scientific literature on depleted uranium, a recent WHO investigation found no convincing evidence indicating any health impacts to the Kosovar population associated with the use of depleted uranium.

In January, a team comprising an environmental specialist, a medical epidemiologist, a chemical toxicologist and a statistical epidemiologist went to Kosovo. The mission—whose purpose was to see if the use of depleted uranium munitions had any consequences on the health of the Kosovar population—was requested by the Special Representative of the United Nations Secretary-General and Head of the United Nations Interim Administration Mission in Kosovo (UNMIK).

WHO’s team called on a large number of health institutions and other organizations with the purpose of gathering data on non-communicable diseases and congenital birth defects and seeing if any trends could be discerned. The team also visited several depleted uranium munitions impact sites to see if credible pathways existed for movement of depleted uranium particles to the local population through the food chain or water supply.

Epidemiological work was difficult due to incomplete population data and a fragmented, inadequate health information system that clearly needs improving.

Nevertheless, the mission report advises UNMIK to take some precautionary measures to reduce remaining concerns. Public information is important. The population should treat penetrators containing depleted uranium in the same way as land mines, and should report sighted penetrators to the authorities for removal. Impact sites should be cleaned up as part of the existing de-mining program. Uranium in drinking water should be added to the parameters that are routinely measured, although contamination from depleted uranium is unlikely.

Written by M. Henry (henrym@who.int) based on ‘The Report of the World Health Organization Depleted Uranium Mission to Kosovo’ available at: www.who.it/docs/durptmar01.pdf

The Mediterranean Council for Burns and Fire Disasters

WHO’s Collaborating Centre for Prevention and Treatment of Burns and Fire Disasters works to prepare for and mitigate the effects of fire disasters. The collaborating centre, formerly called the Mediterranean Burns Club (MBC), carries out emergency humanitarian missions to manage fire disasters, prepares and implements health education for the prevention of burns & reduction of fire disasters and conducts training to improve burns therapy.

MBC publishes the quarterly journal, Annals of Burns and Fire Disasters, and has a very active programme of conferences, courses, scholarships and field missions.

For further information, please contact R. Buhakah at buhakah@cres.it or visit their website at www.medbc.com.

For more information please contact MBC via e-mail at mbc@mbc.cres.it or visit their website at www.medbc.com.

For further information, please contact R. Buhakah at buhakah@cres.it. To subscribe to the Guinea crisis listserv, please email guinea-crisis@who.ch
Ebola Training Video

This 54-minute video has been produced by the World Health Organization for use in training health personnel to respond to outbreaks of Ebola haemorrhagic fever. All aspects of the emergency response – from identifying cases and investigating outbreaks to preventing further transmission and dealing with the press – are illustrated and explained in this comprehensive training tool. The video incorporates footage recorded during recent outbreaks in several African countries, thus facilitating understanding of the actual conditions faced during efforts to contain the disease and trace cases and contacts. Particular attention is given to safety precautions in hospitals.

The video has five parts. A brief introduction to the epidemiology of the disease is followed by information on the identification and management of cases and contacts. Outbreak investigation and epidemiological surveillance are covered in part three, which includes advice on how to combat rumours and calm fears in the community. The fourth and most extensive part provides detailed instructions for the institutional management of patients and prevention of further transmission. The video concludes with advice on the educational needs of health staff and the families of patients.

Available in English and French.
Sw.fr. 60.–/US $54.00; in developing countries: Sw.fr. 42.–

Shorter version for the general public
A 24-minute version of this video, aimed at the general public in areas at risk, is also available.
Sw.fr. 40.–/US $36.00; in developing countries: Sw.fr. 28.–

To place an order, email bookorders@who.ch

Civil Protection, Defence and Safety

To learn about national civil protection, civil defence, civil safety and emergency management structures around the world, consult the International Directory, 2001.

In the context of an international approach to disasters, it is important to clarify the organisation and scope of national civil protection, civil defence, civil safety and emergency management services, particularly for those responsible for coordinating prevention or response activities in the face of disasters by making available to them information on national partners with whom they may be called upon to collaborate.

This second edition on the International Civil Defence Directory provides a clear and structured presentation of the management of emergency situations in over 100 countries. This directory is the result of collaboration between the International Civil Defence Organisation and States which, through the information it contains, will certainly facilitate cooperation at the regional and international levels, as well as contributing to strengthening national civil protection defence, safety and emergency management structures.

Copies are available in Arabic, French and English for USD 33 of CHF 50, and can be requested at icdo@icdo.org

Management of the Child with a Serious Infection or Severe Malnutrition

This manual gives small hospitals in developing countries expert advice on the management of young children suffering from serious infections or severe malnutrition. Addressed to doctors and senior nurses, the manual aims to provide all the practical and technical guidance needed to facilitate quick decisions and life-saving interventions. Conditions covered range from pneumonia, diarrhoea, and severe malnutrition to malaria, meningitis, and measles.

The approach to management relies on a limited number of drugs, laboratory investigations, and practical procedures. Recommended lines of action combine the latest clinical knowledge with extensive practical experience concerning what works best when resources, drugs, and equipment are limited.

The core of the manual provides detailed treatment instructions for individual clinical conditions, specifying the standard course and duration of treatment. Separate chapters cover the management of over twenty diseases in children presenting with cough or difficult breathing, diarrhoea, and fever. Additional chapters cover the management of common problems in young infants, of children suffering from severe malnutrition, and of children with HIV/AIDS. The remaining chapters provide detailed guidelines for supportive care, propose a system for the regular monitoring of patients, and offer advice on when and how to discharge the child from hospital.

Further practical assistance is provided in five appendices, which offer an illustrated guide to the performance of practical procedures, list recommended dosages and regimens for some 57 drugs, give formulas and recipes for treating severely malnourished children, and provide tables and charts for assessing nutritional status and recovery. Advice on play therapy and the construction of simple toys is also included. The manual is part of a series of documents and tools that support the WHO Integrated Management of Childhood Illness initiative.

Available in English; Arabic, French, Portuguese, Russian, and Spanish in preparation.
Sw.fr. 15.–/US $13.50; in developing countries: Sw.fr. 10.50

To place an order, email bookorders@who.ch
International Travel and Health

This annual guide, updated each January, issues authoritative advice on the medical and personal precautions needed to protect the health of international travellers. Addressed to physicians, tourist agencies, airlines, and shipping companies, the book presents the latest information on general precautions to be taken by all travellers, health risks specific to different geographical areas, vaccinations recommended or advised by WHO, and vaccinations legally required for entry into each of the world’s countries. Though the main emphasis is on prevention, country-specific information on common diseases may also help physicians track the cause of illnesses acquired abroad.

The first chapter provides a country-by-country list of required vaccinations, together with pertinent information on the malaria situation, for every country in the world. For malaria, epidemiological details are given for all countries with endemic areas, including notes on geographical and seasonal distribution, altitude, predominant species, and status of resistance. The recommended chemoprophylactic regimen is also given for each country with malarious areas.

Further information on geographical risks is provided in the second chapter, which alerts readers to the main arthropod-borne, foodborne, and water-borne diseases and other health hazards commonly found in different parts of the world. The next chapter offers advice on what travellers can do to protect their health while abroad, whether from the risks posed by contaminated food and water or from diseases spread by insect bites. A comprehensive list of all vaccinations recommended or advised by WHO is presented in the form of a table, which includes information on the vaccine, lower age limit, number of days before the vaccine becomes effective, and duration of protection. The chapter also communicates WHO advice on the immunization of HIV-infected travellers and on the risk of tuberculosis transmission during air travel.

Available in English; French in preparation.
Sw.fr. 17.–US$ 15.50; in developing countries: Sw.fr. 11.90
To place an order, email bookorders@who.int

Global Water Supply and Sanitation Assessment 2000 Report

The Report presents the findings of the fourth assessment of the water supply and sanitation sector. It contains water and sanitation coverage estimates, and supports investment, planning, management, and quality of service decisions in the sector. The methods used for Assessment 2000 differ from those of previous reports. By focusing on users as primary sources of data, rather than on providers, the report provides a more accurate estimate of the present state of water supply and sanitation around the world. As a result, the assessment provides the baseline and monitoring methodology that will ensure reliable and consistent statistics with which to report progress.

Sw.fr. 35.–US$ $41.50; in developing countries: Sw.fr. 24.50
To place an order, email bookorders@who.ch

Scurvy Control in Emergencies

Scurvy and Its Prevention and Control in Major Emergencies is now available on-line. This document reviews past experience with the strategies used to prevent scurvy among populations affected by emergencies and analyses factors influencing their success or failure. Included in the document are a literature review of the epidemiology of scurvy and its signs and symptoms, the properties and functions of vitamin C and recommended daily allowances, and a discussion of food sources of this vitamin and its stability.

Scurvy manifests itself 2-3 months after consuming a diet lacking in vitamin C that is mainly found in fruit and vegetables. It is characterised by multiple haemorrhages and, left untreated, is fatal. Outbreaks of scurvy have occurred frequently in populations affected by emergencies and who are dependent on international food aid. In 1994, scurvy outbreaks were reported in camps in Eastern Ethiopia, among Somali and Ethiopian refugees in Kenya, and among Bhutanese refugees in Nepal. The prevention of this deficiency has been an ongoing concern for nutrition and health professionals for well over a decade.

The document is available on-line at http://www.who.int/nut/documents/scurvy_in_emergencies_eng.pdf or by request to weiseprinzo@who.ch

Thiamine Deficiency in Emergencies

Thiamine deficiency occurs where the diet consists mainly of milled white cereals, including polished rice and white flours, but also starchy foods such as cassava and tubers, all very poor sources of thiamine. This deficiency disease can manifest itself within 12 weeks of deficient intake and can cause disability and death. Large segments of the world’s population continue to subsist on marginal or sub-marginal intakes of thiamine. People exposed to subclinical conditions of thiamine deficiency are predisposed to manifest thiamine deficiency (beriberi), occasionally in epidemic proportions (e.g. The Gambia in 1988 and 1990). Outbreaks of thiamine deficiency have also occurred, for example, in refugees in Thailand (beginning 1980’s), in Guinea (1990), in Eastern Ethiopia (1993), in Djibouti (1993/1994) and in Nepal (1993-1995).

The review document (Thiamine Deficiency and its Prevention and Control in Major Emergencies, WHO/NHD/99.13) attempts to document the risk factors leading to such an outbreak, to describe the signs and symptoms of the deficiency disease and to discuss strategies and possible interventions to prevent it from occurring in the future. The document reviews the epidemiology of thiamine deficiency, the functions and properties of the vitamin B1 and its sources as well as its stability in foods.

The document is available on-line at: http://www.who.int/nut/documents/thiamine_in_emergencies_eng.pdf or by request to weiseprinzo@who.ch
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