World Health Organization

Emergency and Humanitarian Action

ANNUAL REPORT
2001

Department of Emergency and Humanitarian Action
Geneva, July 2002
Introduction

For some time at least, 2001 will go down in people's memory as the "Year of September 11". But, as a matter of fact, the year had opened with an earthquake in El Salvador, immediately followed by the earthquake in Gujarat and another in El Salvador. Poverty remains a main factor of risk. As more people live in vulnerable areas, hazardous materials and rapid industrialization contribute to mass tragedies such as the explosions in Nigeria and the refuse landslide in Manila. However, the year saw also bush fires threatening affluent areas of California and Australia, and terrorism showed that also the rich can be at risk. Complex emergencies in the poorest countries, though, remain the focus of attention. Starting with a renewed international outcry for the unacceptable levels of mortality prevailing in the Democratic Republic of Congo, 2001 closed with violence escalating in Palestine and recovery trying to coexist with relief in Afghanistan.

Significantly, in 2001 the UN Secretary General also called for peace to be mainstreamed in humanitarian and developmental strategies. The past twelve months saw humanitarian action become more complex and stakes grow further across the international community. Security and national preparedness are seen as political imperatives, with public health an essential component therein. Accurate and timely health intelligence is viewed as critical. Coordination is difficult; the number of health-related actors is constantly increasing, and there is great demand for accountability and quality standards. WHO is especially challenged to deliver under these circumstances, but member countries, agencies and donors have the right to expect that the Organization, as UN technical agency, be the leader in coordination of health response, as well as in building capacities for preparedness in the health sector.

Emergency and Humanitarian Action are central to WHO global functions. The permanent offices that the Organization has in most, if not all the countries and territories that are most vulnerable to disasters, give WHO a comparative advantage in this area of work ("we are there before, during and after a crisis"… See also box 1) but also greater responsibilities. Emergencies or "exceptional situations" cannot be an excuse to accept the unacceptable: they just make it imperative that exceptional action is taken for public health. Even in the direst circumstances there are key measures that can save lives, and WHO sees them as its core responsibilities, commitments to its constituents in any emergency (see box 52 on page 37).

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

Emergencies are about unpredictability and instability. Instability can be envisaged along a spectrum defined by the different interplay of natural and man-made factors of risk. At one end, "Utopia" represents an ideal, all-stable condition, e.g. an equitable society fully integrated in the global political economy. At the opposite end, in "Chaos", instability and unpredictability reign, e.g. the society is shattered and the State itself applies violence against its own citizenry (see box 2). Natural and/or man-made hazards are effectively managed in "Utopia", but they are left unchecked until

they materialise as disasters in "Chaos". In "Utopia" all systems function and vulnerability is essentially individual and determined by biological factors. At the "Chaos" end, vulnerability is largely collective and defined by socio-economic factors. Conceptually, there is a strong rationale for different approaches to public health.

Emergency and Humanitarian Action is a horizontal function of WHO internal co-ordination, service and support. This function is especially focused on the needs of the field, but also looks at what WHO in general may need to design programmes that are more resilient to external shocks, and more effective also in difficult circumstances. The Department of EHA is the instrument that assists WHO to perform in emergencies and humanitarian action, as part of an international response system.

In 2001, WHO kept up with a fast changing environment while fulfilling its responsibilities in the area of Emergency Preparedness and Response. Activities were implemented through a network hinged on EHA in Geneva and EHA units and programmes in the six WHO regional offices. The earthquake in Gujarat, the crises in the Democratic Republic of Congo, West Africa, Palestine Occupied Territories and Afghanistan constituted the major, although not the only share of work, that was altogether marked by interaction between Geneva, regional offices and country offices and dialogue between EHA and technical partners in WHO.

The first chapter of this report, Providing services and fulfilling responsibilities carries an overview of WHO/EHA work at country and regional levels. The second chapter, Global action for preparedness and response focuses on the EHA Department in Geneva. The third chapter, A process of growth highlights some positive change and outstanding challenges in this area of work. In the first months of 2002, following changes in its direction, EHA-Geneva underwent two reviews and an internal general staff retreat. The findings and the numerous recommendations of the three exercises can be accessed in EHA files. To a degree, they are also reflected in the last section of the report: Looking ahead. However, in order to reconcile brevity with the need to keep record of the work done and acknowledge merits, the report deal mainly with facts, and try to steer clear from value judgements.

Finally, an apology and a commitment: while trying to give an overview of WHO global work for emergency preparedness and response, this report is still very much focused on EHA activities and not enough on those of other departments, and they are many, that are relevant to this area of work. "Enhanced coordination and exchanges within WHO" is an expression often found in the following pages. We hope to be able to produce a more comprehensive picture with next-year report.

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2 see:
- Aide memoire from EHA Departmental Retreat, Chavannes de Bogis, 20-21 February 2002
I. Providing services and fulfilling responsibilities: six Regions working at emergency preparedness and response

The frontline of WHO’s work for emergency preparedness and response runs across its country offices. WHO has active field presence in most member countries and each year one office out of five has to face at least one emergency. Country presence is sustained by the regional offices and is now increasingly extended downstream with decentralised sub-offices and active outreach. Increasingly, staff who are well experienced in emergency response are out-posted in the field, with assistance from multiple WHO technical departments.

Thanks to its nature of UN Specialised Agency and its statutory relationship with Member States, WHO is in a unique position to influence Ministries of Health and ensure technical and operational coordination with external actors. Thanks to its long term presence at country level, WHO has also regular and active communication with the government and non-governmental health structures that are closest to the people, at times even involving non-state actors. This is important, because, no matter if under-equipped, under-supplied or disrupted, national and local health systems are indispensable for any humanitarian or developmental effort.

Thus, together with the responsibility, WHO also has the assets needed to deliver health in exceptional circumstances. The following section cannot be comprehensive, but provides a good summary of the measures adopted by the different regions to meet the challenges facing them in 2001.

![2001 UN Consolidated Appeal Benefiting Countries](image)

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3 “... for local health workers, no population is really ‘inaccessible’ ..” (J. Everts, 2002)
REGIONAL OFFICE FOR AFRICA (AFRO)

Emergencies affect Africa on a daunting scale, and prompt response is essential for the survival of hundreds of thousands of people. Complex emergencies and extreme economic conditions erode national capacities for preparedness and response even as efforts are being made to build them up. There are encouraging signs of growing awareness of Ministers of Health and national leaders, and growing understanding within WHO of the need for preparedness. However, due to lack of institutional resources, the regional EHA unit remains very small in relation to the scale of the needs: 43 highly vulnerable countries, 23 of which are in complex emergency.

In 2001, WHO's African Region worked at developing a sustainable institutional base and national capacities for emergency preparedness and response in all the member countries, while at the same time supporting urgent interventions and/or responding directly to major ongoing crises.

Rather than developing a large team in the Regional Office, a decentralized pool of 12 country-based experts was created. These experts, posted in WHO country offices and/or in Ministries of Health, are all trained by AFRO and can be called upon to assist in their own and nearby countries, both for programme development (vulnerability assessment, national and local planning) and for emergency response. However, the Region still needs to rely on international expertise from global level, at least at short- or medium-term.

In the Regional office, EHA also collaborates with other technical divisions and units, so to ensure that they are geared up to operate in emergencies. For example, in 2001 country staff responsible for nutrition and for emergency preparedness were brought together jointly by the regional EHA and Nutrition units, to design together nutrition emergency interventions.

Highlights

In 2001, AFRO had to face the entire spectrum of emergencies: from chronic armed conflicts to acute natural (floods) and technological disasters (urban fires). Country and regional office had to put considerable efforts in health emergency coordination and different forms of operational support for the health sector in Angola, Burundi, Rwanda, Republique Centro-africaine, DR Congo, Republique du Congo, Eritrea, Ethiopia, Uganda, Tanzania; Kenya Guinée, Sierra Leone, Liberia, Mozambique, Nigeria.

Throughout the year, the Democratic Republic of Congo remained the epicenter of humanitarian concerns in the Region, with new surveys reconfirming the burden of excess mortality due to the civil war found in 2000\textsuperscript{4,5}. A joint UNICEF/WHO mission traveled across the country assessing the health crisis. Following this, the two agencies brought together in a technical meeting health officials from four rebel-controlled

\textsuperscript{4} IRC: Mortality in Eastern Republic of Congo. New York, 8 May 2001
\textsuperscript{5} Mortality in Eastern DRC-Results from Five Mortality Studies. Prepared by Les Roberts, IRC Health Unit, 2000.
areas and from Kinshasa, and regional and international experts. The meeting defined a minimum package of health services, flexible enough to be applied both in acute and chronic emergencies, that gives a detailed account of the life-saving activities that can be implemented at community and at health unit levels to address the main seven killers: malaria, measles, diarrhoeas, acute respiratory infections, malnutrition, maternal risk and HIV/AIDS. The package is integrated by guidelines for surveillance, training and financing that support in the same measure all these interventions with a transversal, integrated platform (see figure 2)

The plight of DRC is intimately connected with the parallel crises and instability in all the surrounding countries: the sub-regional WHO Coordination Office, based in Nairobi, was re-activated for the ongoing crisis in the Great Lakes.

Before moving slowly towards a solution, the complex emergency in West Africa spilled over into Guinea where a WHO sub-office had to be established in Kissidougou to respond to a sudden refugee influx.

Following the floods in Mozambique, Southern Africa saw a growth of interest in preparedness and WHO was actively involved. AFRO supported the Disaster Management Structure of the Southern African Development Community (SADC), besides providing technical support for hospital emergency planning to individual member countries in that sub-region.

AFRO supported Swaziland in a vulnerability assessment for communities at risk of drought and Niger for the development of the national plan for emergency preparedness and response.

In a meeting of national WHO/EHA focal points organized by AFRO in Pretoria, South Africa in October 2001, countries reported their progress in setting up national EHA entities, and countries which have not yet done so committed themselves to creating national EHA units.

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6 A note of special grief was the tragic death of Dr Kassi Manhlan, WR-Burundi, in October 2001
The AFRO vision for the future is to move from relief to risk management and from ad-hoc actions to a programme approach: this will require time, human resources development, advocacy, resources, and continuity of efforts. In 2002, EHA AFRO will focus on:

i. having emergency units established in all Ministries of Health,
ii. supporting these units with training, strategy and programme ideas and tools for assessment and planning,
iii. developing further the regional network of consultants and improving the information exchange between countries,
iv. improving collaboration with WHO-Geneva, particularly around the Consolidated Appeal Process
v. improving the performance of WHO country offices in their leadership role for emergency health coordination
vi. intensifying cooperation with sub-regional bodies (SADC, IGAD, etc) so to improve cross-border work and general public health for populations on the move.

Between two Regions: The Horn of Africa Initiative (AFRO and EMRO)

In 2001, the cross-border initiative for health in the Horn of Africa (HOAI) was revitalised. AFRO and EMRO prepared together a set of Phase II proposals, and a coordinator was posted in Addis Ababa. The HOAI addresses public health systems and needs in the border areas that join Djibouti, Kenya, Eritrea, Ethiopia, Somalia, Sudan and Uganda. As a contribution to the overall sub-regional security, also in the context of the Inter-Governmental Authority for Development (IGAD, a body gathering these seven countries), the HOAI focus its work on strategic coordination around common problems and specific health aspects of early warning, community preparedness, food security and conflict mitigation. The idea is to maximize opportunities for access to health care along these borders: "health security for the poorest of the poor". For Phase II, cross-border dialogue will concentrate on strengthening the complementarity of the member countries' health services in the border districts. Polio surveillance and eradication, and cross-border control of communicable diseases are high in the agenda, together with enhanced communication and exchanges between border districts and the promotion of health projects as a channel for area-based development aid and a substantial bridge for peace.
REGIONAL OFFICE FOR EASTERN MEDITERRANEAN (EMRO)

In 2001, EMRO strengthened its EHA unit with new personnel under the direct supervision of Senior Management. Training for preparedness was implemented in key countries such as Afghanistan and Pakistan, together with a comprehensive programme of competency building for field staff in collaboration with Geneva. A first inter-country seminar also discussed strategic options for Health as a Bridge for Peace in the Region.

After September, though, most of these activities had to be downsized as EHA/EMRO took responsibility for the coordination of health relief in the new and massive crises exploding in and around Afghanistan and in the Palestine Self-Rule Areas, that represented the events of highest profile in the entire year.

**Highlights**

**Afghanistan**. On 15 October 2001, the DG appointed a WHO Regional Coordinator for the Crisis. Throughout the most acute phase of the events, WHO managed to deliver on its core commitments in Afghanistan through 22 international and 177 national staff posted in 8 offices and 22 operational sites. The Polio network carried out the NID in Afghanistan as planned and ensured surveillance also for tetanus, measles and other diseases. In Pakistan, WHO strengthened assistance to border districts so to provide capacities for health referral. WHO-Iran provided coordination, training and supplies for Western Afghanistan and was instrumental in controlling an outbreak of Crimea Congo Haemorragic Fever. Joint missions organised between EMRO, EURO and Geneva conducted assessments in the areas of nutrition, communicable diseases, essential drugs, information, logistics and communications.

By end October, a first set of health priorities had been identified, to guide the strategy of WHO and health partners. WHO was a major player in the International Conference on Reconstruction of Afghanistan in November, and organised a Health Sector Reconstruction Workshop in December. WHO returned to Kabul as soon as the Interim Authority established a Ministry of Public Health (MOPH) in Afghanistan. There, it assisted the national authorities in implementing a measles immunisation campaign, and represented the health sector in the World Bank/UN Preliminary Needs Assessment, in

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7 “Whether in the emergency or the post-conflict reconstruction phase, the most important thing is to save and improve lives... This is our number one goal,” Dr. Gro Harlem Brundtland, Press Release WHO/51, 26 November 2001
preparation for the Tokyo donors’ meeting of January 2002. Already in the first months of the crisis, a remarkable amount of humanitarian assistance for health was channeled through WHO for Afghanistan: from the UK, Norway, Italy, Kuwait, USA and Korea.

**Occupied Palestinian territory.** During 2001, the conflict worsened: with growing armed violence, deaths and injuries increased dramatically on both sides. WHO assists the Palestinian Ministry of Health with a regular programme focused on maternal and child health, non-communicable diseases, mental health and health promotion. Furthermore, since 1994, WHO runs a Special Technical Assistance Programme (STAP) for enhanced capacity building. In 2001, STAP was expanded to deliver emergency supplies as well as technical assistance for health assessment, humanitarian co-ordination, advocacy and communicable disease control. A vulnerability study of the health sector was conducted to guide the action of the Palestinian Ministry of Health and external assistance.

**Somalia.** The slow progress out of the complex emergency still suffers of precarious health conditions, malnutrition, cyclic outbreaks of cholera and measles, special vulnerability of women, children, elderly and IDPs, well entrenched endemic diseases like tuberculosis and emerging threats like leishmaniasis. Lives are still at stake and limiting avoidable mortality remains the priority. Rebuilding the health services, though, demands also to remedy the steady drain of health skills by training and manpower development. In 2001, WHO continued to lead work for public health and health sector recovery, in coordination with local national authorities, UNICEF, UNFPA, and local and international NGOs.

**Sudan.** In 2001, health interventions provided a bridge for conflict mitigation in South Sudan. The WHO-supported Early Warning system (EWARN) for outbreak control was expanded to include the Government controlled part of the South. In July, a joint WHO/UNICEF appeal to the warring parties allowed for the safe passage of teams investigating polio cases in the Upper Nile. All together, Polio NID and distribution of vitamin A reached over five million children.

In 2001, almost 83,000 people were affected by floods and displaced in 13 states in Northern Sudan. The successful management of this crisis, of an outbreak of meningitis and, more in general programmes dealing with communicable diseases, bear evidence of the good collaboration ongoing between national authorities, WHO, UN agencies, local and international NGOs. WHO supported the Government with technical assistance, emergency health kits, bed nets, sanitation equipment and pesticides. Health professionals and volunteers were trained in search & rescue and needs assessment for greater preparedness against future floods.
REGIONAL OFFICE FOR EUROPE (EURO)

The Region is moving out of ten years of political changes, wars, civil strife, breakdown of lifeline systems, shortages of basic goods and services that severely impacted on the health status of the most vulnerable. Europe experiences relatively few disasters; however, some foci of complex emergency continue; for all the Region, environmental degradation, obsolete industrial plants and chemical pollution pose natural and technological threats, especially in view of the high concentration of population in vulnerable areas (e.g. Northern Turkey).

The Regional Office recognises its key responsibility in strengthening the capacity of national health structures for preparedness. For this purpose, after securing a credible and visible presence at field level through an EHA office, EURO concentrates on two lines of work:

i. operational: providing direct assistance to affected countries: training, supplies, expert advice and enhancing of the co-ordination of humanitarian aid;

ii. normative: developing a package of country support activities to be carried out before, during and after an emergency

The work of EHA/EURO is characterized by a very proactive use of health information: all country programmes publish at least one newsletter and the Region features a rich EHA webpage.

In EURO, the absence of a tradition of country offices prior to the 1990s meant that the humanitarian offices set up during the war in Former Yugoslavia de facto became “the WHO offices” for the external observer; for WHO though, they were temporary offices. Some of them are praised for the roles they played during the war, but now they may deserve to be reconsidered in a different perspective. The current challenge for EURO seems to be how to phase out EHA work at country level, handing over responsibilities to "non-emergency" programmes and mechanisms, or redirect the efforts in the direction of explicit, long-term country programmes for health sector preparedness in some states in Eastern and South Eastern Europe.

The Region is not short of needs - besides the known foci of civil strife, it is also at risk of natural and technological disasters- nor of opportunities. Civil Defence is ingrained in Europe's culture and the Region includes six of the WHO collaborating centres for emergency preparedness and response. One of them, the Zaschita Institute in Moscow, has exceptional capacities and presence all across the countries and territories of the former Soviet Union.

In 2001, while the situation was progressing towards stability at least in the Balkans, EURO had to assume the additional burden of participating in WHO response to the early stage of the Afghan crisis, through its member states in Central Asia.

A strategy of communication

All EURO/EHA country programmes publish at least one newsletter

- Health Action in the North Caucasus
- Health Action in Tajikistan
- Health Action in Albania
- Health Action in Kosovo
- Health Action in the Federal Republic of Yugoslavia
- Health Action in the Former Yugoslav Republic of Macedonia

Box 9

Central Asia: a bridge between EURO and EMRO

WHO offices in the Central Asian Republics (C.A.R.: Tajikistan, Uzbekistan and Turkmenistan) played a key role in the early stages of the Afghan crisis. Through EURO, WHO was able to preposition resources - supplies, logistics and staff - very close to Afghanistan in a critical phase characterised by the feeling of major impending humanitarian crisis, scarce information and extremely fluid planning scenarios. A WHO sub-regional office was established in Termez on the Uzbek-Afghani border. WHO country offices in the C.A.R. were strengthened. Through Termez, WHO assisted inter-agency assessment and support missions in Northern Afghanistan. From Tajikistan, WHO worked at strengthening cross-border malaria control. After a meeting between the authorities of the two countries, Tajikistan, in consultation with WHO office in Kabul, established a training centre for health professionals from Afghanistan.

Box 10

8 Information on EURO/EHA activities can be found at: www.euro.who.int/emergencies.
**Highlights**

*The North Caucasus* (Chechnya and Ingushetia, in the Russian Federation). In 2001, the complex emergency did not abate. WHO kept coordinating the work of 18 NGOs that provide health care to IDPs, and strengthening the skills of local PHC workers, with special focus on disease surveillance, mother & child care and rational use of drugs. Given the persisting high risk of tuberculosis among IDPs, WHO and the Russian Ministry of Health managed to reinforce the local services, so to provide firm ground for the DOTs. Psycho-social problems remain a priority and WHO supports community-based rehabilitation.

*The Former Yugoslav Republic of Macedonia.* In 2001, inter-ethnic armed conflict broke out. While continuing its regular plan of country cooperation, WHO conducted a rapid assessment of the health capacity and needs in the affected area, co-ordinating health humanitarian assistance and providing essential health services for the IDPs.

*Albania,* the UN-Administered Province of Kosovo, Yugoslavia and Tajikistan, the year 2001 saw WHO and the national health sector progress from an emergency mode to a more developmental one. In all these countries, WHO shifted the focus of its cooperation unto health sector reform, collaborating with local health authorities in capacity building and in coordinating the inputs of major donors such as ECHO and the World Bank towards the Sector's recovery and re-development.

Among EURO success stories of 2001: the decreases in malaria and typhoid incidence achieved in Tajikistan - 40% and 23%, respectively, as compared to 2000, the number of Kosovars (over 2000) who passed through the capacity building programme set up by the UN, NGOs, KFOR and local health institutions, the presence of WHO as member in the health reform commission and the national UNAIDS group in Yugoslavia.

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**Evaluation of WHO work in Kosovo June -December 1999**

**Summary of conclusions**

In Kosovo, WHO played a substantial role in early policy setting and co-ordination. WHO's strength is that it has considerable technical capacity and can be seen as the neutral broker for equitable health for all the population.

Producing the health newsletter – and posting regional public health advisers are examples of good co-ordination tools.

Medium term health policy guidelines prepared by WHO gave direction to international players and helped direct 'emergency' resources towards recovery; they could have been expanded with technical guidelines and be used as a co-ordination tools.

**Weaknesses that will have to be addressed**

- Stakeholders expected stronger co-ordination from WHO.
- Direct implementation should be limited so as not to undermine the key roles that can only be performed by WHO.
- Lack of strategic planning and internal co-ordination between various WHO programme components; late arrival of a Head of Mission; insufficient delegation of authority and skills to the local office.
- WHO's success in this early phase had much to do with the extensive support from the main donor, DFID. WHO will have to reduce such dependencies.

See also [www.who.int/disasters/evaluation](http://www.who.int/disasters/evaluation)

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

In August 2001, following a request by the European Centre for Minority Issues (ECMI) WHO conducted in Geneva a workshop with a group of Kosovar experts from different political parties, that debated issues relevant to the reconstruction of the health system in their society.

The report of the workshop can be accessed on [www.who.int/disasters](http://www.who.int/disasters)

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**Box 11**
In 2001, PAHO's Emergency Preparedness and Disaster Relief Co-ordination Program (PAHO/PED) continued to give priority to local capacity building for preparedness, mitigation and humanitarian supply management. The Program saw its performance at regional level grow, resulting in national readiness at country level. This was achieved -and is maintained- through a long work in skill-building and experience-sharing, outreach to other PAHO programs, cooperation with ministries of health, other sectors of government, the disaster community in the Americas, civil and military, regional and international institutions.

For disaster preparedness, manuals and training materials were produced and updated, for the use of health partners in the Region. There was an increase in training events and initiatives of inter-country cooperation for preparedness and mutual assistance at national and subregional levels. Of special interest in this area the course "Lideres" for health sector senior managers. Worth of mention was also the enhanced use and distribution of information hinged around the regional Disaster Information Center (CRID) in Costa Rica, and the creation of specific sub-regional web sites.

As far as disaster mitigation is concerned, PAHO/PED works along two complementary lines. Health facilities (hospitals, water systems, etc…) are vulnerable to disasters, and must be protected: therefore, PAHO/PED conducts and/or assists structural and non-structural vulnerability analysis in member states, then assists so that appropriate mitigation measures are adopted for key public health infrastructures. All this calls for advocacy among public, professionals, government and the media, development of human resources, technical assistance in the design of new infrastructures. A second line of work deals with integrating disaster reduction in the work-plan of other divisions of PAHO in Washington (especially Health Services and Environmental Health) and in the country offices, so to get synergies with, and added value from all activities of the Organization.

Disaster reduction and emergency management are essentially made of reliable partnerships. In this line, in 2001 PAHO, besides representing another regional institution -IACNDR⁹- in the Task Force of the UN International Strategy for Disaster Reduction (ISDR), also strengthened its direct collaboration with ISDR, whose regional office is housed within WHO/PAHO since its establishment.

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⁹ Inter American Committee for Natural Disaster Reduction established by the Organization of American States
Humanitarian Supply Management. PAHO/PED continued promoting SUMA among humanitarian agencies at global and regional level. Technical work continued to develop and improve the SUMA management system with partners. There are increasing instances of SUMA being adopted as part of national policy in Latin America. Inter-country SUMA teams have been established and deployed in case of emergency. Humanitarian supply management is a major element of PAHO/PED work in emergency response, together with assessment, project identification and coordination of international health assistance, mobilization of appropriate financial and human resources, consolidation and dissemination of emergency health information and advocacy.

PAHO/PED strategy for disaster reduction has been sustained over 25 years with a stable base of core staff that has maintained the vision and direction. The result is a credible and respected programme covering the Region. The lesson learned is clear: building capacities for disaster reduction is a long- and difficult- developmental process that demands institutional stability and that must be sustained in spite of competing priorities on the basis of a simple forethought: "What if?". Disaster reduction is essentially investing in people and institutions with enough continuity to induce positive changes.

The experience of the Americas is that disaster reduction needs to be seen as a core function of the Ministry of Health that should establish a programme or department with specific responsibility for the health aspects of disaster reduction. This programme must coordinate with the national institution responsible for overall disaster management - be it the Prime Minister Office, the National Prevention and Relief Agency, the Civil Protection or other - and other relevant actors in the public and private sectors in order to gain the necessary credibility vis-à-vis the public and among the other national institutions.

**Highlights**

**Colombia.** By the end of 2001, after multiple population displacements, 250,000 new IDPs brought the total of displaced population at an estimated 1.5 Million. Each of the new IDPS, individuals or groups, must have access to health services as quickly as possible, as a matter of urgency, and then be integrated into the "normal" system, same as the rest of the population. In order to meet this challenge, the PAHO-Colombia reorganized its technical cooperation and included attention to displaced populations as one of the three cross-cutting issues. Five field offices of the IDP project are being opened to allow direct coordination at the local level with NGOs supporting the access of IDPs to local health services and servicing as a broker with central level resources. This will improve the synergies between the emergency and development approach.
Two major earthquakes struck the country in January and February 2001. In addition to moving into the country within hours/days with 25 experts, PAHO/WHO mobilized over 200 more staff for the health sector priorities. Success stories were the comprehensive view of public health that PAHO/WHO promoted with its partners, as well as the role in sectoral resource mobilisation and coordination that it was able to play for UNICEF and UNFPA (see Box 16).

Later, an interdisciplinary workshop of over 200 participants was conducted on the lessons learned in the earthquake relief, which permitted the identification of shortcomings and successes for future use in improving the country's preparedness.\textsuperscript{10} The active participation of key UN agencies, such as UNICEF, UNDP etc. has contributed to the relevance and sustainability of this educational process, closing consequently the loop between impact, response and preparedness.

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\textbf{Box 16} &  \\
\hline
\textbf{US$} & \\
\hline
I. Public Health and Overall health sector co-ordination WHO/PAHO & \\
II. Child and psycho social rehabilitation UNICEF & \\
III. Water and Sanitation UNICEF & \\
IV. Immunisation, mother and child health care and nutrition: UNICEF & \\
V. Reproductive health. UNFPA & \\
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\textbf{TOTAL} & \\
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\textsuperscript{10} Proceedings in Spanish are available on the PAHO web site (\url{www.paho.org/disasters})
REGIONAL OFFICE FOR SOUTH EAST ASIA (SEARO)

SEARO concentrates on building the capacities and self-reliance of its member countries for preparedness and on mitigating the health consequences of the disasters. Key concerns are how to develop appropriate alert mechanisms and how to link emergency action with measures for sustainable health development. In 2001, dynamic work at country level - where preparedness programmes are often tested by the extreme events that regularly affect the Region - was complemented by innovative inter-country initiatives and growing inter-regional collaboration with WPRO and AMRO/PAHO.

Highlights

**Bangladesh.** With about 130 million people, most of them living in poverty and exposed to annual floods and cyclones, Bangladesh is rightly considered one of the most vulnerable countries in the World. In the area of emergency preparedness and response, WHO assists the national authorities in needs assessment and provides technical and financial support to gearing the health information system towards the specific needs of emergency management. In 2001, WHO support to the Ministry of Health included technical guidelines and standard operating procedures for the management of public health in emergencies, as well as a national workshop was held on policy and legislation for emergency preparedness.

**Democratic People's Republic of Korea (DPRK).** Since 1997, EHA has been instrumental in channeling WHO assistance to DPR Korea. In 2001, the Organization's presence in Pyongyang was scaled up to the full functions of Country Office headed by a Representative. The new arrangements allow for greater collaboration with the Government and UN Agencies and a more explicitly developmental approach to the Country's health needs. In the past twelve months the combined efforts of the Ministry of Public Health, UNICEF, UNFPA and WHO produced substantial results. Polio eradication is on track; the national EPI programme was re-established and coverage is increasing; malaria control activities increased; TB control was expanded to cover 65% of the population. Nutritional rehabilitation can take place in almost 170 facilities around the country; Vitamin A supplementation reached 98% of the children 6 months - 5 years old; production of Iodised salt started in seven locations, while local production of six essential drugs for common diseases is being established. After years of isolation, technical collaboration is becoming a significant, although still small component of international assistance to the health sector; meanwhile, capacity building of both individuals and systems is given higher priority. WHO work in DPRK is more and more recovery and development driven.

### Bangladesh, 1996-2001: cyclones, floods and storms

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</tbody>
</table>

Source: EM-DAT: OFDA/CRED International Disaster Database- www.cred.be/emdat - Université Catholique de Louvain - Brussels -
**East Timor**: WHO has been working in East Timor for the past two years. During this period, WHO contributed to international efforts: first for relief and later for transition and development. The dynamics of development in East Timor require that WHO continues providing technical guidance and support in the health sector, which is seen as a priority component of the process. In 2001, the EHA unit in SEARO continued collaborating with the other technical programmes to mobilise resources and start activities in Health system and human resource development, disease surveillance, malaria and tuberculosis control, essential drugs. Further efforts covered mental health, laboratory services, HIV/AIDS, IMCI, Safe Motherhood, Nutrition, Water and Sanitation. In May 2001, a team of two reviewers examined WHO’s performance in the first year of Independence (see box 19: the report of the evaluation is also available on the EHA web site at www.who.int/disasters/re po/7333.doc).

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### East Timor: evaluation of WHO performance

**East Timor** was an unprecedented challenge for the humanitarian community. In May 2001, the Government of Australia sponsored an external review of WHO's performance in East Timor from September 1999 through August 2000. The reviewers drew the following conclusions:

**INITIAL RESPONSE.** By establishing a surveillance system and by getting involved in the co-ordination of health activities from the first day of its presence in Dili, WHO fulfilled its mandate. At the onset of the crisis, WHO appropriately addressed the survival needs. Later, WHO focused too much on health services and not enough on policy issues. WHO’s authority in health co-ordination was affected by curtailed initial presence and by lack of “instruments of authority.”

**IN THE POST-EMERGENCY PHASE.** WHO support to East Timor's Interim Health Authority (IHA) was of relative importance if compared to the number of full-time advisers. WHO’s approach to capacity-building was too focused on training; insufficient attention was given to ownership and empowerment of nationals. International NGOs appreciated WHO’s willingness to partner with them, but had problems with WHO administrative processes. Within WHO, there were different understanding of the Organization’s roles and responsibilities. This impacted upon co-ordination, communication and relationships also with partners. However, WHO’s success in assisting UNTAET, other agencies and NGOs contributed to the health sector being widely regarded as the most advanced in East Timor.

**Lessons to be learned:** WHO should be better prepared: this would imply forecasting, strategic planning, identifying clear lines of authority, maintaining a roster of experts for rapid deployment and establishing the necessary logistical and financial provisions. Meanwhile, guidelines and general information should be disseminated on WHO’s role and functions in co-ordination. More in details

- (a) WHO should have rapid access to un-earmarked funds so to bridge over until CAP funds are secured,
- (b) conceptual and management factors need to be addressed, so to reduce delays to the submission of proposals and in the release and transfer of funds,
- (c) arrangements with donors need to be de-bureaucratised and accountability strengthened,
- (d) WHO should have a clear focal point for emergency action.

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**Gujarat, January-March 2001: main areas of activity of WHO**

- Sharing and updating key health information and supporting the Government in health sector coordination;
- Assessing the health needs of populations in affected areas in cooperation with UNDAC;
- Supporting the management of commonly occurring diseases;
- Advising the Government, UN agencies, bilateral agencies and NGOs on public health priorities;
- Supporting the government in establishing disease surveillance, early warning and capacity for rapid response to epidemics in the affected areas;
- Providing and facilitating the provision of trauma kits, emergency health kits and other essential supplies;
- Offering technical support for emergency repairs of water, sanitation and solid waste disposal, food safety, vector and zoonosis control;
- Supporting re-establishment and rehabilitation of health services in affected areas with special attention to primary health care.

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**India.** On 26 January 2001, a major earthquake hit Gujarat. It affected five cities and almost 9,000 villages: a population of about 4 million, of which 17,000 were killed and 1,450,000 injured. In the first days, what was left standing of the local health services had to treat 145,000 serious casualties. The day after the event, WHO had a team in the field and on 9 February, seventeen WHO professionals were assisting the local health authorities in the affected area. The WR re-deployed several of its Polio and TB staff to support emergency work. After one week, the WHO field team included 4 senior public health experts, 5 medical officers, a sanitary engineer, an information office,
administrative and logistic staff. WHO provided funds and equipment for a new epidemiological cell under the District Health Authorities. Rapid surveillance and response teams fanned out across the affected area, working under WHO guidance. A WHO field sub-office was set up to coordinate work until communications were re-established. After the relief phase, WHO-India maintained a decentralised presence in Gujarat, assisting the State health authorities in coordinating action for rehabilitation and reconstruction all throughout 2001. In mid-2001, the lessons learnt in Gujarat were the subject of a regional WHO workshop. Two important spin-offs of the lessons learnt exercise and of the continuing field work were enhanced collaboration between WHO and IFRC all across India, and the growth of awareness and interest in emergency preparedness on the side of the State Health authorities and institutions in Gujarat.

**Indonesia.** Emergency preparedness and response is a substantial part of WHO technical collaboration in Indonesia. In 2001, while in some area WHO continued to be focused primarily on crisis management, health relief and contingency planning (see box 21), the Country Office was also able to take a wider and longer-term approach to preparedness for the health sector. While continuing to ensure the health aspects of humanitarian coordination across the country, WHO started assisting the Ministry of Health in establishing an information system for emergency preparedness and early warning. Plans are underway for WHO to assist the national authorities in conducting an assessment of vulnerabilities and capacities in the health sector at national level.

**WHO in Indonesia: assessments, health as a bridge for peace and internally displaced persons**

- **West Timor:** all WHO activities were interrupted in September 2000. At the end of 2001, work resumed with health assessment in the refugee camps, disease surveillance, immunizations, mental health, that are planned to continue and expand in 2002.

- **Maluku:** WHO started operations in Ambon in March 2001, focusing on drug supply and management, disease surveillance, health manpower development. A need assessment was conducted in North Malukus in May. In June, when WHO staff had to be evacuated, activities continued thanks to the working groups set up jointly with the local authorities that had been trained in the context of the Health as Bridge for Peace (HBP) programme.

- **Madura:** The influx of IDPs started in February 2001; current local estimates are of 120,000 IDPs in a population of 780,000. Most IDPs are accommodated in private homes. WHO supports epidemiological surveillance in the camps and host communities, well-building in critical areas and health education and promotion.

**Box 21**

**Nepal.** Emergency preparedness is an integral part of the WHO country cooperation. Besides epidemics, floods, landslides, and civil strife, Nepal is threatened by the ever-present possibility of a major earthquake. This would cause massive destruction of urban areas and infrastructure, including essential assets such as lifeline systems and hospitals. The threat is serious enough to warrant permanent readiness. Since 1999, the UN Disaster Management Team has been engaged in developing UN Nepal’s Disaster Response Preparedness Plan. Apart from actively taking part in this process, WHO coordinates emergency planning in the health sector, which gained momentum since the year 2000. The planning process is chaired by senior representatives from the Ministry of Health and is implemented through a national Disaster Health Working Group. In addition, WHO conducted various mass casualty management training programmes and the seismic vulnerability assessment of 14 hospitals in the Kathmandu Valley.

**Myanmar.** Myanmar is one of the "forgotten crises", or "silent emergencies" so often mentioned these days. The country is not covered by any Consolidated Appeal Process (CAP), but internal armed strife has been festering for almost 30 years in the periphery of the country. In 2001 better relations between the Government and the international community resulted in an increase of the flows of external assistance. Some funds were channeled through the EHA Unit in SEARO, to be managed by the WHO Country Office in collaboration with the Ministry of Health, mainly for reproductive health, control of malaria, HIV/AIDS and tuberculosis. Access to health services and health status are assumed to be particularly poor in the rural and more peripheral areas. Infant, child

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11 The Government of Italy pledged about US$ 300,000 through WHO/EHA for control of TB and HIV/AIDS in Myanmar along the border with Thailand.
and maternal mortality are very high, with obstetric hazards and communicable diseases being the major share of the burden of disease. The new funding and inter-country synergies (see box 22) provide the opportunity to strengthen disease surveillance and general reporting from the border areas.

**Box 22**

**Myanmar-Thailand: The Border Health Project**

Health status is especially precarious in Myanmar's border areas. Limited access to health services contributes to many specific challenges that interact with people's migration into Thailand. These challenges require inter-country collaboration. In July 2000, the ministries of health of Thailand and Myanmar, assisted by WHO developed an action plan for joint control of malaria, HIV/AIDS and TB. In support to this initiative and on the spur of a crisis caused by an outbreak of unknown origin later that year, WHO posted a technical officer as full-time Cross Border Programme Coordinator in the office of WHO-Thailand. The coordinator works on the whole range of the health problems along the border, with specific attention to the priorities defined by the two neighbouring ministries. Already in 2001, WHO's work in these difficult areas produced a better understanding of the determinants of the health of the migrant population, thus allowing to identify which activities and best practices need to be given priority.

**Thailand.** About 110,000 persons live in 9 camps along the border with Myanmar; a much larger number live outside the camps, with no entitlement to assistance in health and food and often facing different barriers in accessing health services. They often live in poverty, without adequate sanitation: the public health risks are high, both for the newcomers and the surrounding communities. Case finding and long-term follow-up treatment for diseases such as tuberculosis are particularly difficult. This is of global concern, with respect to Multi-Drug-Resistant tuberculosis and calls for cross border collaboration (see box 22).

**Sri Lanka.** As this report is being typed (June 2002), Sri Lanka seems to be advancing on the road to peace. However, nearly two decades of armed conflict in Sri Lanka have severely affected the population living in the North and Northeastern part of the country. In 2001, the health situation deteriorated due to the escalation of the conflict. The war between the Government and the LTTE, together with other contributing causes has left 65,000 dead, 800,000 IDPs, 1 Million refugees. Lack of access to health services and shortage of medical supplies are common experiences. Malaria is the most common communicable disease in the areas of strife. Health initiatives have been able to promote a degree of co-operation and understanding between the conflicting parties. Health as a Bridge for Peace (see box 23) is demonstrating its value as a tool by which WHO can help the Government and NGOs provide health services in conflict-affected areas.

**Box 23**

**Health as a Bridge for Peace in Sri Lanka**

*Don't discount people's will for peace*

**Process**

1999- WHO organises a regional Health as a Bridge for Peace (HBP) workshop in Sri Lanka
2000- Sri Lanka organises a national workshop for health managers from "both sides"
2001- Sri Lanka organises an HBP Training of Trainers workshop

**Outputs**

1. HBP skills are used in day-to-day health work, in and around conflict areas;
2. HBP trainers train provincial level PHC staff;
3. HBP trainers educate colleagues in the Army and Navy;
4. Ministry of Health conducts HBP training for Tamil population in areas susceptible to race riots;
5. Sri Lankan trainees travel as resource persons to start HBP in Indonesia.

**Outcomes**

1. Army Medical Services were instructed to cater to "enemy" community in newly captured areas;
2. MOH provided mobile health services in areas not under government control;
3. Sinhala and Tamil villages were involved in joint projects in conflict areas;
4. There are plans to integrate "rebel" health workers into formal health services;
5. Elements of HBP are incorporated into University curricula.

**WHO's total investment: approx. US$ 170,000**
The Western Pacific Regional Office (WPRO) works at reducing the immediate and long-term avoidable mortality, morbidity and disability in emergency situations caused by both natural and technological disasters. In the area of emergency preparedness and response, WPRO identifies five priority issues:

- Recurring extreme natural events and growing technological hazards,
- Increasing number of vulnerable communities,
- Weak institutional capacity of principal health organizations for emergency management,
- Insufficient collaboration among partner agencies, mostly focused on response rather than preparedness,
- Insufficient collection, analysis and dissemination of public health information on disaster and emergency situations.

In 2001, WPRO continued collaborating with the Member States, working at strengthening emergency management capacity across the Region and assisting countries affected by emergencies. The EHA unit in the Regional Office provided technical advice, supplies and equipment and/or mobilization of funds, participating in assessments, and organizing workshops for planning and training. The focus of WPRO country programmes is in assisting ministries of health to develop and decentralise their institutional capacities, while promoting community-based initiatives for risk reduction. In the same perspective of building capacities where they are most needed, WPRO translated into Chinese and Vietnamese two WHO manuals, one dealing with preparedness and the other with rapid health assessment. The manuals were distributed for the use of health workers at provincial and community levels. Translations into Khmer are also underway.

In 2001, the Regional EHA unit looked at avenues and practical measures aimed at enhancing WPRO institutional capacities for emergency management. Consultations were held with all WRs and work started to adapt for regional use the WHO Handbook for Emergency Field Operations. Meanwhile, a standing Emergency Management Task Force was established in the Regional Office, ready to be activated in case of major emergencies.

WPRO undertook a study on what the member countries would require in terms of information for greater preparedness, of what is available at regional and global levels, and of what would need to be done to fill the gaps. The exercise culminated in an inter-country workshop held in Manila in July 2001, where the national EHA focal points from all member countries discussed how to establish a Regional Information System for Emergency Management (RISEM). The participants agreed on a common terminology proposed by WHO, on standard formats and mechanisms for information exchange, and on supporting RISEM through concerted country initiatives. In an another, important and complementary initiative, WPRO organised a sub-regional workshop on the lessons learned during the floods of the Mekong (see box 24).
Also collaboration with different agencies and other WHO regions - mainly SEARO and PAHO - provided WPRO with further opportunities to assess the Region's vulnerabilities and build capacities in member countries accordingly. WPRO collaborated with the Asian Disaster Reduction Center (ADRC-Kobe) to develop a Regional Disaster Profile Database, that brings together various databases sited in different institutions. Collaboration with the Asian Disaster Preparedness Center (ADPC-Bangkok) and the Japan International Corporation of Welfare Services (JICWELS-Tokyo) promises to deliver an inter-regional, inter-agency steering committee on human resource development program for emergency management.

EHA/WPRO Programme Summary

**Regional Goal**
To reduce suffering, and immediate and long-term avoidable mortality, morbidity and disability related to emergencies

**Regional Objectives**
- To strengthen both national and community emergency preparedness
- To mitigate the impact of hazards on health and health system
- To improve institutional capacity for emergency response

**Strategies for 2001-2003**

1. Enhance WHO’s institutional capacity
2. Promote proactive consultation process
3. Strengthen national capacity building activities
4. Support “Country Projects”
5. Develop a regional information system for emergency management
6. Assist community-based risk reduction initiatives

**Regional Issues**

1. Recurring and/or increasing hazards
2. Communities with high vulnerability and insufficient readiness
3. Insufficient public health information on emergency
4. Need to strengthen institutional capacity for emergency management
5. Lack of proactive collaboration among partner agencies

Box 25
## WHO: area of work Emergency Preparedness and Response for Health, 2001

EHA regional and inter-regional initiatives of global interest and major country programmes

<table>
<thead>
<tr>
<th>Region</th>
<th>Regional level</th>
<th>Sub-regional level</th>
<th>Country level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AFRO</strong></td>
<td>Network of national and sub-regional focal points</td>
<td>Great Lakes West Africa &lt;br&gt; <em>HOAI</em>: Kenya, Uganda, Ethiopia, Eritrea</td>
<td>Democratic Republic of Congo, Burundi, Rwanda, Republique Centro-Africaine, Republique du Congo, Sierra Leone, Liberia, Guinea, Angola, Mozambique, Zimbabwe Eritrea, Ethiopia</td>
</tr>
<tr>
<td></td>
<td>AFRO/EHA Web page</td>
<td>Horn of Africa Initiative (HOAI)</td>
<td></td>
</tr>
<tr>
<td><strong>EMRO</strong></td>
<td>Health as a Bridge for Peace &lt;br&gt; Health and Human Security</td>
<td><em>HOAI</em>: Sudan, Somalia, Djibouti &lt;br&gt; <em>CAC</em>: Iran, Afghanistan, Pakistan</td>
<td>Afghanistan &lt;br&gt; Occupied Palestinian territories &lt;br&gt; Sudan &lt;br&gt; Somalia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Central Asia Crisis (CAC)</td>
<td></td>
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<tr>
<td><strong>EURO</strong></td>
<td>Translation of EHLK in Russian</td>
<td><em>CAC</em>: Tadjikistan, Turkmenistan, Uzbekistan</td>
<td>FRY Macedonia, Albania &lt;br&gt; Tadjikistan, &lt;br&gt; Russia/Northern Caucasus &lt;br&gt; Uzbekistan, Turkmenistan &lt;br&gt; Yugoslavia</td>
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<tr>
<td></td>
<td></td>
<td>Mitigation in hospitals</td>
<td></td>
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<tr>
<td><strong>PAHO/AMRO</strong></td>
<td><em>&quot;Lideres&quot;</em> Translation of Manuals &lt;br&gt; CD-Rom: HELID Global SUMA Manual on logistic management of humanitarian supplies</td>
<td>Barbados Sub-office &lt;br&gt; Costa Rica Sub-office &lt;br&gt; Equador Sub-office</td>
<td>Colombia &lt;br&gt; El Salvador</td>
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<td>Zaschita, CRED, S. Marino, Palermo, IC MH Fondation Mérieux</td>
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<tr>
<td><strong>SEARO</strong></td>
<td>Revision of Handbook &lt;br&gt; Revision of RHAP Health as Bridge for Peace</td>
<td>Thai-Myanmar Border Health Project</td>
<td>East Timor, DPR Korea &lt;br&gt; Indonesia &lt;br&gt; Bangla-Desh &lt;br&gt; India, Nepal, Sri-Lanka</td>
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<td>Calcutta</td>
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<tr>
<td><strong>WPRO</strong></td>
<td>WPRO Handbook RISEM</td>
<td>Preparedness in the Mekong Basin</td>
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<td>Xhangai</td>
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*Figure 3*
II. GLOBAL ACTION FOR PREPAREDNESS AND RESPONSE

Managing crises: mobilising resources in support of local health systems

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

Sudden alerts pose evident challenges: for instance, in the early days of the Afghanistan crisis, EHA had to set up a situation room staffed 24 hours per day, with a total additional workload of 30 professional months. However, in many ways, work can be even more difficult in the face of the many, protracted crises that turn chronic, or in the phase that follows an emergency, when health needs and expectations become more complex and public health management more challenging, if one wants to contribute effectively to stabilization and the return to development.

In EHA-Geneva, a team for Emergency Health Partnership comprising 16 staff coordinates between the country and regional offices and a network of focal points in other WHO departments, operational partners, collaborating centers, donor agencies, etc that can provide additional, specific technical resources as needed. In this manner, the expertise of the entire Organization can be brought to bear close to the needs. Each Desk Officer is expected to provide immediate technical advice, mobilise extra assistance from WHO’s technical departments and external partners and, in general ensuring all the technical and logistic back-stopping that may be needed.

Besides including frequent field missions - e.g. to assist in rapid health assessments - the above demands clear views on technical priorities, precise information on what WHO can deliver i.e. the Core Commitments, availability around the clock, capacity for teamwork and interpersonal skills.

Working to mobilise and optimise resources

In 2001, in order to support the emergency activities of WHO, EHA maintained contacts with 27 different donors. 18 of them responded positively. During the year, EHA channeled 98 new donations, amounting to a total of about 26 Million USD

| Global programmes run by EHA-Geneva | 45 |
| Inter-regional programmes supported by EHA-Geneva | 32 |
| Country level operations conducted by EHA-Geneva (e.g. delivery of supplies) | 230 |
| AFRO country programmes run with support from EHA-Geneva | 74 |
| EMRO country programmes run with support from EHA-Geneva | 3 |
| EURO country programmes run with support from EHA-Geneva | 26 |
| SEARO country programmes run with support from EHA-Geneva | 81 |
| WPRO country programmes run with support from EHA-Geneva | 35 |

source: WHO/AFI

| Working together January-December 2001: missions from EHA-Geneva in assistance to regional and country offices |
| AFRO:........113 P.staff days |
| AMRO/PAHO:.....................0 |
| EMRO:........93 P.staff days |
| EURO:.........32 P.staff days |
| SEARO:.........2 P.staff days |
| WPRO:.........5 P.staff days |
| Total.............245 P.staff days |

(It does not include duty travel for global programmes)
Prompt technical advice and coordination are vital. However, the acute phase of most emergencies sees the affected population and the local systems as the main, often the only actors: the paramount concern is to bolster local response capacities with the right supplies. Through EHA, WHO is one of the stakeholders of the UN Humanitarian Response Depot (UNHRD) in Brindisi. WHO uses the Depot to maintain and operate a buffer stock of emergency medical kits - New Health Emergency Kits and other specific kits: for mass trauma management, cholera control, etc - that in 24 hours can be deployed anywhere in the world.

**Disseminating health intelligence and knowledge**

Another WHO function in emergency preparedness and response - supported by a team for *Emergency Health Intelligence and Capacity Building* - is to produce, consolidate and disseminate information on health-relevant issues, as well as standards and best public health practices as relevant to preparedness, response, rehabilitation and recovery. In 2001, this function was strengthened by recruiting a senior epidemiologist.

In 2001, the WHO Emergency Health Library Kit (EHLK) was supplemented by a CD-Rom "Health Library for Disasters". The CD-Rom contains over 300 publications in three languages, and thanks to donor support, can be distributed free or at production cost to field workers. Keeping the EHLK and the CD-Rom up-to-date with the publications by WHO or other authoritative sources is a continuous activity, that provides useful spin-offs in terms of joint advocacy, training, operational partnerships, etc. The Bibliography on Best Public Health Practices in Emergencies (produced and disseminated in 1999), was joined by a new set on the *Epidemiology of Emergencies*.

EHA's quarterly newsletter *Health in Emergencies* highlights health problems and activities in the context of emergencies worldwide. Each issue includes a feature section, focusing on a specific topic and a second section with information on programmes, workshops, training events, new publications, etc... *Health in Emergencies* is distributed in hard copy to 2,500 people. It is sent by e-mail to approximately 400 people and is posted on EHA web site.

EHA web site, [www.who.int/disasters](http://www.who.int/disasters) wants to assist field workers and planners with public health guidance for humanitarian action and up-to-date contextual information. In 2001, about 70 new technical documents were published or linked to the page. In the same period, more than 1000

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12 Started together with PAHO, the collaboration for the CD-ROM included UNHCR, ICRC and the SPHERE Project thanks to a grant from DFID-UK. The complete collection can be viewed at [www.helid.desastres.net](http://www.helid.desastres.net)
different situation updates, field reports, etc were posted, as gathered through EHA focal points in the field, regional offices, and partners. The web site covers 69 countries variously affected by emergencies and 16 regional or specific crises. In order to reach closer to partners and users at field level, two listserves\textsuperscript{13} were established (each with about 150 subscribers, within and outside WHO) on the emergencies in DRC and Afghanistan.

In order to assist operational partners in their field work, EHA also develops tools for easier information management. In 2001, a first tool package was designed and posted for downloading on the Web page. The package carries introductory notes, an assessment/reporting template, instructions for completing it and a table of reference values and is available at: www.who.int/disasters/sitrep.cfm

Effective emergency management must be based on good public health practice, but health action must be based on good management, too, and especially so in emergencies. Evaluation and research are key to this line of work. Evaluation of humanitarian action is still very much an infant discipline and in 2001, while supporting the evaluations in Kosovo and East Timor, EHA produced a first technical/policy draft for internal discussion. The draft takes into account other initiatives that are underway elsewhere within WHO, so to ensure coherence of broader organisational policies. As far as external partners' policies are concerned, EHA represents WHO in the Active Learning Network for Accountability and Performance in humanitarian aid (ALNAP), which provides good guarantees of connectedness. Under research, two literature reviews were completed, one on the role of health policies in emergency coordination and another on health system planning during protracted crises. The two protocols for field study are ready, now only waiting for funding.

Through EHA, WHO participated in various research networks. A session on ‘health effects of conflicts and disasters’ was organised by EHA together with CRED\textsuperscript{14} in the Global Forum for Health Research; the need for ethical guidance for research in emergencies was raised at the Roundtable on the Demography of Forced Migration of the US National Research Council. This second topic has long been in the agenda of EHA: it is hoped that guidance can be developed next year.

**Strengthening partnerships by inter-Agency work**

As UN specialised agency for health active in the humanitarian domain, WHO maintains a variety of inter-agency partnerships. Besides traditional alliances such as with UNICEF, IFRC, ICRC and UNHCR, in 2001 bilateral relations grow also between WHO and WFP. Collaboration ranges from technical coordination - e.g. through the "Inter-Agency Health Task Force" in Geneva (IHTF)\textsuperscript{15} - joint training (e.g. ICRC/H.E.L.P courses, OCHA/UNDAC and EFCT), strategic and operational

\textsuperscript{13} Email distribution lists

\textsuperscript{14} Centre for Research in the Epidemiology of Disasters, Brussels

\textsuperscript{15} in 2001, the IHTF included medical officers from ICRC, IFRC, UNHCR, UNFPA, UNICEF and IOM
coordination at HQ and field levels and, increasingly, operational readiness (e.g. with WFP). Through EHA, WHO is an active member of the Working Group of the UN Inter-Agency Standing Committee (IASC/WG) and of its subsidiary bodies (see box 34), as well as of the Advisory Board of the UN Disaster Management Training Programme (UNDMTP) and of the Task Force of the International Strategy for Disaster Reduction (ISDR). Formal memoranda of understanding exist with UNHCR, OCHA and IOM; another is being prepared with WFP.

2001 also saw an effort to strengthen humanitarian alliances between WHO and Non-Governmental Organisations. Besides running the training on SUMA for European NGOs (see page 28), WHO/EHA attended the Interaction Forum in Washington DC, advocating for greater exchange of health intelligence. The British NGO International Health Exchange (IHE) participated in one EHA Induction briefing; MSF-Suisse joined the Inter-Agency Health Task Force coordinated by EHA in Geneva.

Strengthening partnerships by involving the donors
In 2001, donors continued to provide critical support to WHO in emergencies all around the world; as a positive development, there were also signals indicating growing awareness in Member States of the need to invest more on the Organization's own preparedness and readiness.

In 2001 the policy of regular dialogue and stronger liaisons with donors continued, in Geneva as well as in different capitals, e.g. an EHA Medical Liaison Officer was posted in Brussels at the WHO Office at the European Union. A considerable amount of work went into improving the quality of technical and financial reporting, funding proposals, and general information on WHO emergency and humanitarian action. EHA team for Donor Relations provided desk assistance in editing, submitting and following-up on proposals, tracking contributions and reporting. It also supported the Department in liaison with donors and general advocacy activities, like organising exhibits, etc. (e.g. for the launch of the CAP, see page 28).

Periodical meetings were held in Geneva between WHO/EHA and donors, with the support of the Department of Government and Private Sector Relations (EGB/GPR). A donor-focused, monthly bulletin, the “Emergency Preparedness and Response Highlights” and contribution updates were disseminated widely. The donors were associated in the field evaluations conducted in Kosovo and East Timor, while training sessions on project cycle management and resource mobilization were organised for Geneva staff and included in the EHA Induction briefings.

In 2001, reporting and evaluating on the 2000/2001 workplan required a considerable amount of work. The streamlined workplan for the biennium 2002/2003 now provides an easier frame to structure and present WHO work in emergency preparedness and response to outside parties.
III. A process of growth

Signs of progress

Causes and features of crises, as well as humanitarian policies and practice evolve continuously: the same as the theory and practice of public health. WHO’s work with member countries and international partners has to grow and readjust accordingly, and this process can only be open-ended. WHO’s capacity to generate new knowledge in this area and to advise and support countries and other partners needs to be always pushed forwards.

When consulted on what should be on the agenda for the 2001 2nd Global Meeting of WHO Representatives and Country Liaison Officers, the majority of participants suggested a session on Disaster Response and Preparedness. Thus, taking the opportunity of its annual inter-regional retreat, in February 2001, EHA organised a lessons learnt workshop in Bogota, bringing together WRs from all regions, who had in common experiences in different emergencies.

The following March, the conclusions of the workshop were discussed in Geneva in a specific session of the Global Meeting by all the WRs. The technical departments in HQ were also invited to contribute. WRs looked at the different lessons learnt and elaborated how a country office can best prepare for emergencies. The conclusions of their work provided a useful agenda for continuing institutional work (see box 37).

The follow-up process hinged on a number of major milestones

• The concept of the Core Commitments was utilised to promote dialogue with country and regional offices, and within WHO Geneva. Three months of exchanges and technical coordination resulted in a compilation of statements from all WHO departments and programmes on their capacities and priorities in emergencies. The compilation was summarised in a pocket-size booklet, WHO Emergency Essentials, which was widely distributed across the Organization and operational partners and is available at: www.who.int/disasters/repo.8078.doc


1. Vulnerability to disasters and emergency management, as core concerns of WHO, demand a public health approach.
2. WHO has precise responsibilities and unique assets in building national capacities for disaster reduction, from prevention to humanitarian response and early rehabilitation.
3. WHO must assume a more active role in mobilising and coordinating resources for public health in disaster reduction and humanitarian action.
4. There is agreement on the usefulness and feasibility at country level of the proposed WHO’s Core Commitments in Emergencies. In countries, WHO emergency operations must:
   • incorporate outreach, using sub-offices when required;
   • apply technically correct tools (vulnerability analyses, early warning systems, rapid health assessments);
   • account for needs of WHO staff (physical security, length of assignment, psychological stress);
   • allow for rapid reprogramming as required;
   • make use of past experiences, including “best” and “worst” cases;
   • incorporate efficient administrative operations. In particular, administrative slowness undermines our credibility.

Box 36

Box 37

16 Already in 2000, seven out of 10 WRs, when asked to submit case studies for an internal management learning programme, had focused on their experiences in emergencies.
• An *EHA Induction Briefing* was held in July 2001, for EHA focal points and WRs newly appointed to countries in crisis. The Induction gives the participants the opportunity to acquaint themselves with WHO's plan of work for preparedness and response, and with tools such as the Core Commitments and the Consolidated Appeal Process, to express their needs for country work and to be briefed on what WHO can offer in support. The first briefing was enough of a success for a second one to be organised in December 2001, thus bringing to 30 the total of participants in the first year.

• Working on the core commitments and the induction briefing implied greater exchange between EHA and all other WHO departments in Geneva around the needs of country work.

Looking at the perspectives that are opening for Country Offices in the context of WHO's process of changes, EHA collaborated closely with EGB, exchanging views and participating directly with about 30 professional days in activities related to Country Cooperation Strategies and Country Focus Initiative.

<table>
<thead>
<tr>
<th>Comparing immunization strategies in complex emergencies and in routine programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complex Emergency</strong></td>
</tr>
<tr>
<td>Strategy</td>
</tr>
<tr>
<td>Mainly campaign-based (e.g. Pulse immunizations, NIDs)</td>
</tr>
<tr>
<td>Immunization calendar</td>
</tr>
<tr>
<td>Per emergency guidelines (e.g. measles age reduced to 6 months, etc.)</td>
</tr>
<tr>
<td>Target Population</td>
</tr>
<tr>
<td>Denominator usually unknown. Age group extended to 5 years or more.</td>
</tr>
<tr>
<td>Coordination and partnership</td>
</tr>
<tr>
<td>Representatives of populations</td>
</tr>
<tr>
<td>Faction leaders</td>
</tr>
<tr>
<td>UN agencies, NGOs, religious groups, volunteers, health care providers from MoH</td>
</tr>
<tr>
<td>Implementing agencies</td>
</tr>
<tr>
<td>Relief oriented (e.g. working group of the UN (ASC))</td>
</tr>
<tr>
<td>Donor agencies</td>
</tr>
<tr>
<td>Rapid health assessment and epidemic detection by inter-national public health experts.</td>
</tr>
<tr>
<td>Disease surveillance</td>
</tr>
<tr>
<td>&quot;Fast chain&quot; strategy; UN interagency humanitarian logistics, NGOs, the Military</td>
</tr>
<tr>
<td>Cold Chain/Logistics</td>
</tr>
<tr>
<td>EHA/VAB, 2001</td>
</tr>
</tbody>
</table>

Especially intense was the collaboration with the Department of Vaccines and Biologicals (VAB) and the Polio Eradication Programme. One line of work dealt with how WHO, together with UNICEF, could provide the Board of the Global Alliance for Vaccines & Immunizations (GAVI) with a strategy that could suit countries affected by complex emergencies (see box 38). Another area of collaboration EHA/VAB was a study on humanitarian ceasefires, that produced also new ideas for field security: *inter alia*, the possibility to establish a permanent WHO Situation Room. Last but not least, in Gujarat and Afghanistan the Polio teams were instrumental in supporting surveillance and other tasks.

• In 2001, WHO plan of work for Emergency Preparedness and Response in Health for the Biennium 2002-2003 (first drafted at the EHA inter-regional retreat of 2000) was re-discussed with the regional offices and WHO General management in Geneva, and then integrated in the global Activity Management System (AMS). The expected products for the Biennium, strongly focused on the needs of the field, range from policies and strategies,

17 See [www.who.int/disasters/bridge.cfm](http://www.who.int/disasters/bridge.cfm)
18 Technical documentation in EHA/EHC files
health intelligence, support to institutional focal points, advocacy and partnerships, to competencies building and good practices for public health and management in emergencies.

- In September the plan of work was presented by EHA at the 2nd international meeting of WHO collaborating centres for emergency preparedness and response, hosted by the Mediterranean Burns Council in Palermo. It was a good opportunity to ascertain the centres’ interest in continuing their relationship with the Organization along the new lines of work.\textsuperscript{19}

2001 was also a year rich in inter-agency initiatives in the area of disaster reduction and humanitarian assistance.

- OCHA agreed with WHO to introduce basics of vital statistics and public health in the curriculum of the induction of the UNDAC teams (UN Disaster Assessment and Coordination).

- Work for stronger coordination among humanitarian agencies continued. Besides the work with the Inter-Agency Standing Committee (IASC, see below), EHA represented WHO in the processes revolving around the Emergency Managers Meeting, the UN Joint Logistic Centre (UNJLC) and the Humanitarian Information Centre (UNHIC).

- For the Humanitarian Segment of the ECOSOC 2001, in July, WHO produced a statement (\textit{Intelligent Solidarity} see box 39) that together with

\begin{boxed_text}
\textbf{From the statement of WHO at the Humanitarian Segment of ECOSOC 2001}

\textit{Intelligent Solidarity}

As leader in global health, WHO wants to reduce the avoidable death and suffering that result from any type of natural or man-made disaster...

In armed conflicts, most people die of preventable causes: malnutrition, malaria, diarrhoeas, pneumonia, HIV/AIDS, tuberculosis, maternal deaths and epidemic diseases. WHO works so that this fact is reflected in the CAP and properly tackled by all its partners....

WHO approaches human survival and health in a broad perspective that encompasses medical care, water, sanitation, nutrition, disease control, immunization, family and mental health. WHO provides overall technical coordination and health intelligence targeted to decision-making in the field. In addition WHO has specific operational responsibilities such as health assessment and surveillance, and coordination with the local health actors....

WHO disseminates public health practices to ensure best technical performance from all working in the field and facilitate dialogue between national and international actors. Because those first called to respond to a crisis are the people affected and local systems are keys to all relief efforts, same as inter-sectoral collaboration, WHO fully supports coherence, collaboration and solidarity within the Humanitarian Coordination and UN Country Team mechanisms....

WHO thinks that fair job opportunities for national -or refugee-health workers are key to preserve local capacities and calls for more attention to issues of local human resources management in humanitarian programmes....

The psychosocial aspects of disasters cannot be reduced to a matter of mental health, but there is a need to better understand them and at the same time respond to the best of our ability. WHO sees action in this area a necessary contribution of public health to humanitarian assistance.
\end{boxed_text}

\begin{table}[h]
\centering
\begin{tabular}{|l|}
\hline
\hline
1. a common harmonized classification of items/ commodities (UNICEF and WFP lead Agencies);  \\
2. a capacity building initiative for local authorities and NGOs based on the SUMA experience (WHO lead agency);  \\
3. a channels of communication among the community of users (OCHA lead agency).  \\
\hline
\end{tabular}
\caption{Box 39}
\end{table}

Box 39

19 The number of collaborating centres for EPR was reduced from 15 to 11. The report of the meeting can be accessed on \texttt{www.who.int/disasters}

\begin{table}[h]
\centering
\begin{tabular}{|l|}
\hline
\textbf{International Workshop on Logistic Support Systems (LSS) in humanitarian operations}\textsuperscript{19} - July 2001  \\
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\hline
\end{tabular}
\caption{Box 40}
\end{table}

Box 40

- Also in July 2001, WHO and PAHO together with WFP and OCHA, convened in Geneva an \textit{International Workshop on Logistic Support Systems (LSS) in humanitarian operations}. The meeting recommended that a global information system be developed for...
the management of relief supplies in disasters and emergencies. After the meeting the four organizing agencies produced a proposal calling for donors' support in the order of 6 Million US$. The proposal foresees a common classification of relief items, capacity building for local authorities and NGOs (for which WHO was given responsibility) and stronger channels of communication among the community of users.

- Later in the year, PAHO and WHO-Geneva conducted a training on the Supply Management System (SUMA, see also page 12) for representatives of member countries and European NGOs. WHO presented the LSS concept to the consultative group and the advisory panel of OCHA Military and Civil Defence Unit (MCDU) and to the 4th All Africa Congress on Military Forces and Health held in Luanda at the end of the year. Work started for the translation of SUMA software and manuals into Turkish and Russian. The Global SUMA project aims to establish decentralized regional user support and a web-based discussion on accountability and transparency UNJLC.

- In November, in Geneva, Dr Bruntland launched the Consolidated Appeals for 2002 on behalf of the entire UN System, under the title Reaching the Vulnerable. The Appeal called for international assistance in the order of US$ 2500 Million. Out of this total, US$88 Million represent vital health requirements that WHO identified in consultation with the affected States and all partners in health.

For the launch of the CAP, besides facilitating coordination and liaisons with OCHA, EHA supported WHO’s participation in eight other events that were part of the global launch around the world. In Geneva, a round table brought together some 90 representatives from NGOs, donors, UN agencies and the local University and the community to facilitate an exchange of views on concepts and practices of health partnerships in humanitarian crises. A document carrying an overview of WHO contributions to the CAP worldwide was distributed as a one-spot reference.

From Dr. Brundtland's speech at the global launch of the Consolidated Appeals for 2002
- "Reaching the Vulnerable"
Geneva 27 November 2001

"We are here today to focus on people who face grave threats to their lives: the 33 million vulnerable people in 22 countries and territories who are caught up in humanitarian crises. We want to see lives being saved, well-being protected and deprivation reduced. We want to promote human security and the stability of societies...

As experiences in the Afghanistan region have shown, emergencies do not disappear if the world's attention shifts. There is suffering and death whether emergencies are in the news headlines or not. They linger on, they fester, and then they erupt again - and sometimes it is only the UN system that is bringing them to the attention of the world community. If we act quickly, we can avert major crises. If we wait until they hit the news, the costs - in terms of lives, livelihoods and cash - can be much greater...

Early and forceful interventions with humanitarian assistance in emergencies is essential. It reflects our collective responsibility as world citizens, and our collective conscience as members of the world community. It is an essential investment in our common future..

The Consolidated Appeals Process is a response to calls from the donor community for an effective, coordinated multilateral humanitarian action. But we need to see a well-coordinated and comprehensive response effort also from donors...

For example, WFP, WHO and other partner agencies have made clear on various occasions that food aid alone loses much of its impact for its beneficiaries if other activities, such as those geared towards improving availability and access to water and health services, remain under-funded...

Most of all, we must keep in mind that in emergencies, lives are lost whether the TV cameras are there to remind us about it or not. We must never forget those who suffer because they are caught up in conflicts and natural disasters. Their lives are frequently encased in misery: the battle to survive is never ending. We must do all we can to sustain life and empower those who are threatened - with respect for their dignity and human rights. This is our duty - to ourselves as a world community.

Box 41
Unmet challenges

WHO enjoys a high degree of respect and good will among its partners for its mandate and work in global health. However, in emergency preparedness and response, WHO meets only partially the high expectations of its stakeholders. The Organization's performance in relief is perceived as not fully predictable. WHO structure is seen as slowing down decision-making and action. Furthermore, expectations from the Member States and international partners are growing: together with response and preparedness, there is an increasing demand on WHO also for leadership and guidance in health sector reconstruction.

The recent years have seen considerable improvements in WHO performance, but these are seen as due to the commitment of dedicated staff rather than to a corporate effort. On the whole, in the opinion of a wide range of partners, WHO is not yet providing the across-the-board coordinated leadership in the health sector that is needed in emergencies. WHO capacities are still limited by a series of factors.

Authority: policy base and development. Emergencies always have large political implications and some major crises require strong leadership by Senior Management in Geneva. Indeed, Dr Brundtland is increasingly vocal on why WHO is committed to emergency work, and this has been and remains vital vis-a-vis external partners. However, the policy base for this area of work needs to spell out also how WHO Geneva assumes this lead role in high profile, and operationally complex emergencies, so to guarantee technical quality and safeguard coordination with the regional offices. Likewise, this policy base needs to underpin the work of EHA, whose area of specific expertise and functions must be clear to all WHO departments and country offices, lest it is perceived as in charge of a vertical programme.

Information: health intelligence, knowledge and communication. The most appreciated of WHO’s qualities is its technical expertise and the authority it provides. Since 1998, EHA has spearheaded WHO work in producing health intelligence in support of emergency management. There is much room for improvement: by collecting information from/on the field, operational partners, etc EHA contributes well to WHO knowledge management agenda. The “Intelligence” side of the EHA web site, though, remains fragile, as inputs from country and regional offices pick up but slowly; maybe because of this, interest of health partners in exchanging information is difficult to sustain. The EHA web site is known but reportedly little used by humanitarian partners. At field level, there is the fact that web connectivity is often poor, as seen in Kissidougu, Goma and even in Kabul. Altogether, WHO’s information culture is not yet up to the standards of openness demanded by emergency management: arguably the Organization is not fully aware, yet, of the value that knowledge has in a crisis, when field managers must process

Capacity for Emergency Management is made of:

- Authority
- Information and knowledge
- Institutions and structures
- Plans and procedures
- Partnerships

WHO, 1993

Lessons learned:

... just went through the folder of the DRC listserv. My impression is confirmed: in 2 months, there have been only 15-20 messages and very few members have been active. It is important to try to understand why the listserv has been used by so few people.

1. The start was difficult, due to scarce technical support, our lack of experience, problems in the mailing list. These initial difficulties may have discouraged some from participating. Lesson: we should start initiatives like this only with full technical support

2. EHA decided to remain “behind the scenes”, limiting our role to the management of the list. Lesson: a more pro-active role from HQ or RO, at least in the initial period, may be important.

3. Maybe organizations have already their communication channels and don’t need a listserv. Or maybe don’t have access to email. The most pessimistic view is that too much focus on operations make them forget how weak their information base is, or that they could exchange information with something of equal value. Lesson: more “marketing”, i.e. providing responses to real problems, fostering demand for such services and using this demand as a leverage to share information.

(EHA- September 2001)

Information: health intelligence, knowledge and communication. The most appreciated of WHO’s qualities is its technical expertise and the authority it provides. Since 1998, EHA has spearheaded WHO work in producing health intelligence in support of emergency management. There is much room for improvement: by collecting information from/on the field, operational partners, etc EHA contributes well to WHO knowledge management agenda. The “Intelligence” side of the EHA web site, though, remains fragile, as inputs from country and regional offices pick up but slowly; maybe because of this, interest of health partners in exchanging information is difficult to sustain. The EHA web site is known but reportedly little used by humanitarian partners. At field level, there is the fact that web connectivity is often poor, as seen in Kissidougu, Goma and even in Kabul. Altogether, WHO’s information culture is not yet up to the standards of openness demanded by emergency management: arguably the Organization is not fully aware, yet, of the value that knowledge has in a crisis, when field managers must process

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20 see HINAP: a Health Intelligence Network for Advanced Planning
21 both listserves established by EHA for the crises in DRC and Afghanistan, grew very quickly to about 150 subscribers, but became “dormant” just two months later (see also box above)
enormous information under pressure, and crave for guidance. Reports are common of field offices seeking HQ's expert advice and receiving no answer at all, or too late, or inappropriate, “text book” style answers.

Institutions and structures. The crisis in Afghanistan exposed important structural bottlenecks within the Organisation. About 30 professional-months (see page 21) had to be diverted from other tasks in EHA-Geneva in order to support the EMRO and EURO.

- Given the key role of regional offices in WHO, only PAHO can be said to have adequate capabilities for preparedness and response. In all other offices, EHA capacities are very scarce in relation to the scope of work: just one/two short-term professionals, often with no direct access to Senior Management.
- At field level, WHO's weak presence and often absent operational capacities (transport, telecoms, etc…) in emergencies are criticised by partners Leadership and guidance are hard to provide with a succession of staff coming in on three and six months contracts and forced to hitch rides in other agencies' vehicles.
- WHO's institutional surge capacity has a very narrow base: EHA-Geneva has no operations support unit, yet; the system of EHA revolving funds can cover up to 1,300,000 USD in cash and supplies, while procedures for additional in-house resourcing need fine-tuning (see below). Keeping roster of suitable experts on call within or outside WHO is a challenge: it must be addressed, but the very fact that it is the object of a flourishing service industry indicates how difficult it is.
- Also in EHA-Geneva, short-term contracts and scarce induction to the job are challenges, the most disruptive outcome being the drain of institutional memory. Growing and often moving under the pressure of events, the Department would need greater reflection on tasks and roles, greater internal exchange, more frequent reflections on "the global context" 22, better management practice, greater focus on deliverables and more structured interaction with other WHO departments and offices.

Plans and procedures. The plan of work developed for the Biennium 2002-03 is a good strategic frame for institutional development in the area of preparedness and response, at global and regional level. It needs to be more explicitly owned by the staff involved and by the rest of the Organization.

- WHO's processes of contingency and operational planning for emergencies do not yet take enough advantage of the contextual information that EHA systematically collects from the field, other agencies, media, journals, etc… (see also points above on information). This matter needs to be urgently addressed in order to meet in full the expectations of WHO Senior Management23.
- Internal coordination and mobilisation in the acute phase of emergencies is ad-hoc, and there is much room for improvement. Reportedly, inter-programme task forces are the practice in some regional offices24. In the case of highly complex emergencies, DGO-lead task forces were activated in Geneva in 2000 as well as in 200125 but this is still far from being an automatic, standard operating procedure. Linkages between regional and global levels task forces still need defining as well as mechanisms for follow-up on the decisions: competitive behaviour and internal discordance in implementation, e.g. expressed by uncoordinated efforts in raising funds, do no service to the corporate image of WHO.

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22 the expertise EHA is essentially contextual: staff must know when and how to request what from technical partners, and be able to identify the public health aspects of inter-sectoral and inter-Agency policies and strategies.
23 this is another area where partners have expectations about WHO's role: ECHO is asking WHO to contribute to their criteria for engagement in complex emergencies.
24 confirmed by AFRO, PAHO, SEARO and EMRO; mentioned in reports by EURO; planned by WPRO
25 for drought in the Horn of Africa and Afghanistan, respectively (and for Southern Africa while finalising this report- Aug. 2002)
**Purpose**

The purpose of this section of the Manual is to outline the policies and procedures to be followed in planning and implementing the Organization's humanitarian response to emergency situations.

**Definitions**

For the purposes of WHO's humanitarian emergency activities, an emergency situation may result from:

- natural or man-made disasters, complex emergencies or any public health situation endangering the life or health of a significant number of people and demanding immediate action;
- complex emergency situations involving significant acts of violence, complicated by an intense level of political conflicts; often associated with serious social and economic collapse and requiring a multisectoral response.

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**Procedures for deploying resources to the field** are often defined as slow during sudden emergencies, and uneven and unpredictable in slow onset and complex crises and in processes of reconstruction (note: where needs may be urgent too). Even routine confirmations of contracts and transfer of allotments can easily take four months. Delegation of authority to field managers remains insufficient. Review of rules for financial and human resources management, procurement, administrations and reporting for WHO emergencies started in 1995-96: many recommendations (among them, section XV.4 of WHO Manual) exist and just need to be fine-tuned and implemented, e.g. taking the opportunity to integrate in the revision of the WHO Handbook for Emergency Field Operations the experience gained in the last two years though the Polio programme and the new requirements arising from the UN M.O.S.S. initiative.

**Partners.** Partnerships begin at home: definitely much more work is needed to consolidate positive trends of greater and more structured interaction between EHA and other departments in Geneva and regional offices.

- **Ministries of Health** are keen. However, with the exception of PAHO and some fortunate case in other regions, the experience is that national health authorities oscillate between two extremes when dealing with emergency preparedness and response: one that reduces it to only epidemic surveillance and control, the other that would see the MOH sustaining a national process of preparedness with just a 3-months consultant from WHO. Much work is still needed for education, training and general capacity building in the health sector.

- **Humanitarian agencies from the UN system and the Red Cross Movement** are very appreciative of any instance of good performance by WHO. On the other hand, they seem well aware of the Organization's limitations: they do observe that the capacity -and thus readiness - to offer leadership in health in emergencies is still limited. They also comment that WHO can be very strong in assuming its role of health sector leader in CAP, but it is often overly technical and not enough geared to coordination, direction and management when it comes to operations.

- **National and International NGOs** are among the most effective actors in emergencies. However, WHO seems to have difficulties in sustaining mutually beneficial relations. From both parties, there is a reluctance in forming close relationships. It can be addressed, at country level, e.g. by WHO adopting an incremental policy of guidelines and brokerage with MOH in exchange for information and services from NGOs, and at global level e.g. in the context of the Civil Society Initiative.

- **WHO has two or three very supportive donors** for EHA projects and operations: they constitute a loyal and predictable, but unfortunately quite narrow resource-base. Other donors appear still confused about WHO and Health in emergencies. Their humanitarian desks have other expectations than the development desks, and the two have little dialogue with each other. This does not help WHO, that promotes linkage between health as a development objective and health in crises: given its importance, this topic may deserve to be pursued more aggressively. WHO is also seen as the weakest among UN agencies in fundraising, reporting and follow up of commitments. Interestingly, at field level donors are more apt to see WHO as having a clear vision and strategy regarding its tasks and role: this raises opportunities for informal contacts that need to be encouraged and followed-up with stronger communication and “marketing” strategies.
IV. Looking ahead

Disasters - and especially complex emergencies - represent an unacceptable burden within the context of the Millennium Development Goals and other development targets. The international community is more and more called to take exceptional action in situations of instability and insecurity, associated with limited capacity and/or collapse of governments, institutions and communities. As UN specialised agency, WHO is called to help focus these efforts in the domain of health: for the Biennium 2002-2003, the Organization identifies the global goal to reduce suffering, immediate and long-term avoidable mortality, morbidity and disability related to emergency situations.

Within this goal, WHO's direct responsibility and manageable objective is to increase the capacity and self-reliance of member countries to prevent and prepare for disasters, thus mitigating their health consequences, and to create a synergy between emergency and sustainable development. In order to achieve this objective, WHO can contribute advocacy, policies, strategies, health intelligence, support to member countries, partnerships, competencies and good practices for public health in emergencies (see box 45).

Already in 2001, much of EHA work reflected these lines. As a matter of fact, over the past few years, EHA has developed a vision that allows for consistent growth through/in spite of the continuous changes inherent to its area of work. The choice to focus on the needs of country offices demonstrated its value vis-a-vis both the global health challenges - growing instability, crises turning chronic, etc- and the developments that are underway across WHO: greater focus on countries, strong sectoral leadership, search for wider alliances, etc. At the end of the year, this vision was rewarded by strong signals of in-House commitment to emergency work, as well as by donors' pledges of support to a stronger WHO role in health coordination in humanitarian crises and high-risk situations. 26

Indeed, political and financial support are and will be needed. Disasters and emergencies are public health affairs and it is imperative that WHO's management of high-risk situations and emergencies is structured so to involve the entire Organization. Ideally, each WHO country office should factor emergencies into its core programming. Furthermore, some countries are at such high-risk, that WHO just cannot afford not to have dedicated resources for emergency preparedness and response in the Country Office; these situations alone would be reason enough for WHO to integrate emergencies in all its policies, strategies and programmes. 27 Preparedness needs a sustained strategy and consistent investment. The process is well on track, although it is realistic to expect that it will take several years to gain its own genuine momentum. 28

26 see Dr Brundtland's statement at the Launch of the CAP 2002 (Box at page 30 of this report), as well as the response of WHO technical departments and donors to the Organisation's efforts at the onset of the crisis in Afghanistan
27 End-2001, almost 25% of Africa's population lived in situations of emergency or very high instability.
28 the most successful WHO programme in this area, PAHO/PED has a history of about 25 years under the same leadership: "there are no magic bullets for disaster mitigation and emergency preparedness, that are essentially long-term developmental activities".
In December 2001, an extra-budgetary grant for institutional support allowed EHA to design a realistic preparedness and response strategy for WHO that addresses the three key elements of presence, institutional knowledge and competencies and surge capacity. This strategy will certainly improve the Organization's response to emergencies of a containable nature. However, it needs to be supported by political commitment at the highest level, because some crises are of such complexity that the people's survival can be guaranteed only if WHO mobilises all its resources and authority in unprecedented and exceptional ways.

(1) establishing a "critical EHA mass" in all regional offices: three professionals with sufficient operational and office resources to guarantee immediate response to crises and to decentralise capacities at least to the sub-regional level, so to ensure continuity of activities for preparedness and response;

(2) ensuring greater stability of quality staff: so to have stronger dialogue with all partners, and develop and sustain the systems for information and decision, and the programmes for knowledge management and capacity building that are needed by national health authorities and international humanitarian actors as well as by WHO;

(3) strengthening WHO surge capacity: by expanding the pool of experts on-call that are familiar with the Organization, by beefing-up WHO's emergency revolving fund and by establishing the process and the procedures to enable the whole of the Organization to mobilise around an agreed strategy whenever the DG deems that exceptional action is needed for public health.

These three axis define the strategic frame wherein EHA can service WHO in delivering health in the context of emergencies and attaining its expected results for emergency preparedness and response in the Biennium 2002-2003.

Policy and advocacy positions. An overall policy for WHO's engagement in emergencies needs defining. Then, for each new crisis EHA will produce a specific strategy. The strategy will be agreed between country office, Region (or regions), Geneva and national authorities and coordinated with UN partners, so to provide the umbrella under which WHO can work. Wide-based collaboration is needed also for advocacy, that can be especially effective at country and regional levels: for humanitarian partners to recognise people's survival and health as the common objective, and to have humanitarian crises factored in the public health model and in the work of ministries of health and WHO; advocacy should rank high in the terms of reference of the regional programme manager. Four themes seem most relevant in the present context: the Humanitarian Use of Military Assets\(^ {29}\), HIV/AIDS in Emergencies, Post-conflict Transition and Reconstruction and Health as a Bridge for Peace.

\(^{29}\) Procedures for the use of international military assets (i.e. personnel, equipment and supplies) in natural disasters were first defined in the Oslo Guidelines, stipulated in 1994. These are now being reviewed to take into account complex emergencies too (for more details see www.reliefweb.int).
Health intelligence, information tools and systems. The critical mass at regional level includes one information manager: stronger regional capacity, possibly extended to the country level in case of crisis, - e.g. by setting up specific web-pages and disseminating tools for data collection and analysis - can sustain the open information system that WHO needs, and foster a corporate culture of information-sharing. In Geneva, permanent surveillance, advance alert, monitoring and regular briefings will be key to WHO's strategies for exceptional action. The EHA website and the Newsletter provide good channels to disseminate the health information collected by countries and regions and the knowledge generated by WHO globally, as well as opportunities for advocacy and profiling WHO's successes.

Work on-going includes the production of Emergency Health Country Profiles, the revision of the rapid health assessment protocols and a series of WHO/EHA Field Tools (floppies, CD-ROM). Other priorities are a review of the audience of the EHA Webpage and wider dialogue within and around WHO on the determinants of health and survival in emergencies.

Political and technical support to focal points in member states and partner agencies. This is at the same time one specific objective of WHO's work and a key condition for its effectiveness. In part, it is addressed by strengthening EHA in the regional offices and facilitating outreach to the sub-regional level, as already done by PAHO and AFRO. In countries in crisis, EHA routinely supports sub-offices, e.g. in DRC, Guinée, Russia, Somalia, India, Indonesia, Afghanistan, and Sudan. WHO needs to be seen in the field; however, WHO can only be as prepared as its partners are: in order to perform, it needs strong national health institutions. Surge capacity must integrate local systems; on their side, local health systems need to prepare to absorb external assistance without being overwhelmed by it. In Geneva, EHA Desk officers continue to play a pivotal role between the needs of the field and the expertise and resources that can address them: brokers who provide advice, identify issues and propose how to meet them. The network linking regions and HQ is getting stronger and adds potential for inter-regional collaboration.

The Core Commitments provide a clear list of priorities for prompt response, while Multi-hazard Preparedness and the Role and Needs of Health in Post-conflict Transitions constitute good leads for work on preparedness and recovery, respectively.

Box 47

WHO functions at country level
- To monitor health status and sector performance
- To build capacity for research, policy and health systems
- To catalyse country-specific application of global public health goods
- To respond to countries’ requests for guidance
- To serve as broker and influence decisions of government and partners for the health of the people
- To work with partners to ensure health is core to the development-poverty reduction agenda
- Where government capacities are overwhelmed or collapsed, to co-ordinate with all partners so to ensure that key life saving public health measures are in place, and to help establish conditions for sustainable health development

WHO/CCO, 2002

Box 48

see, the demand imposed upon national health authorities by the fear of acts of bio-terrorism, etc.
**International partnerships and resources mobilized.** Effective partnerships are rooted at country level, in the relations of WHO with health partners and the system of UN Humanitarian Coordination. The UN Country Team (UNCT), its Consolidated Appeal Process (CAP) and the many other planning exercises\(^31\) can optimise WHO's work for health development and emergency preparedness and response. The WRs are uniquely placed to provide partners with technical leadership and to accommodate this function in the Country Cooperation Strategy. Stronger EHA capacities in the regional offices can support these processes at country level and open dialogue with regional institutions for inter-country initiatives\(^32\). Globally, the IASC/WG is a good forum for all WHO to contribute more to, and get more from inter-agency work, as it is being done with HIV/AIDS in emergencies. The work on the CAP, UNJLC and LSS/Global SUMA is of similar benefit to the Organization, for operations, capacity building, advocacy and brokerage, and it will continue. As part of an effort to strengthen the dialogue with donors on WHO in emergencies, EHA plans to integrate information sharing activities and meetings in Geneva can be integrated by visits to donor capitals for joint planning and joint field evaluations of emergency programmes. Emergency and humanitarian activities need to be more systematically included in the agenda of WHO bilateral negotiations with donors. Especially useful could be tri-lateral relations between Donor, Regional Office and Geneva.

**Good management practice integrated in WHO’s emergency programmes.** Exceptional health action demands prompt decisions, quick delivery and administrative accountability. Engagement must be supported by special procedures, accepted by all levels of WHO. More in general, crises do not allow for bad management\(^33\): stronger surge capacity and presence at require also stronger managerial competencies. Beside a sound public health background, staff need an understanding of WHO's structure and culture; they need to know the tools they have for project cycle management; they need briefing, debriefing, backstopping and support; skills in project identification and formulation, monitoring and reporting need enhancing. The EHA Induction briefings are good opportunities to test the Management Toolkit (see box 50) and discuss the Field Emergency Handbook with their main users. The recent UN initiative for Minimum Operational Security Standards (MOSS) demands close collaboration between EHA and General Management, mainly Security Coordination, for the development of Rapid Response Procedures and Support Kits.

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31 Country Common Assessment (CCA), Development Assistance Framework,(UNDAF), Common Humanitarian Action Plan (CHAP), Inter-Agency Contingency Plan, Flash Appeals, etc.

32 See the work of AMRO/PAHO with the Organization of American States (OAS), AFRO with the Southern Africa Development Community (SADC), EMRO with the Inter-Government Authority for Development (IGAD), SEARO and WPRO with the Asian Development Bank and the Asia-Pacific Disaster Prevention Center (ADPC) in Bangkok.

33 "... in emergencies, mismanagement is a major cause of death..." (J. Telford, 1995)
Evaluation of humanitarian assistance and of WHO performance therein, can foster professional competencies as well as partnerships, and remains a priority in WHO agenda for emergency preparedness and response.

Best public health practices in emergencies identified, updated and promoted. The purpose of WHO work is twofold: to assist partners achieve the best health outcomes, and to draw on individual experiences so to build global public health knowledge. In the area of preparedness and response, WHO's normative function can be summarised by the statement "humanitarian assistance must be based on the best public health practices". EHA will continue to update WHO's Bibliography of public health guidelines for emergency work and disseminate them through the Emergency Health Library Kit (EHLK: "the Trunk") and the HELID CD-Rom. This activity entails technical dialogue across all WHO, with operational partners and collaborating centres: it is well in line with EHA's horizontal function of internal coordination, service and support. Operational research contributes to this chapter of work by identifying gaps in knowledge and new good practices, and by feeding back on whether/how WHO guidelines are in fact available and applied in the field. Finally, Training: the critical EHA mass includes one staff tasked with human resource development in each regional office. Training is essential to build capacities in member countries (although not the only requirement) and WHO's experience is that it is best left to the care of the regional offices and conducted at country level. EHA-Geneva can support at global level. Furthermore, work at HQ level, under the strategic objectives of exposing WHO to greater interaction with humanitarian partners, and promoting WHO views through partners' training activities, promises to foster commonality of views and stronger partnerships for emergency preparedness and response among technical departments.

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34 see Introduction, page 2 of this report.
35 Report from the Evaluation of the WHO Panafri can Emergency Training Centre (PTC) of Addis Ababa - December 1999
36 since end 2001, a full time professional is working on training issues in EHA Geneva
WHO Core Commitments in Emergencies

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

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

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

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ADPC</td>
<td>Asian Disaster Preparedness Center</td>
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<tr>
<td>ADPCA</td>
<td>Asia-Pacific Disaster Prevention Center</td>
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<tr>
<td>ADRC</td>
<td>Asian Disaster Reduction Center</td>
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<tr>
<td>AFRO</td>
<td>Regional Office for Africa</td>
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<tr>
<td>ALNAP</td>
<td>Active Learning Network for Accountability and Performance</td>
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<tr>
<td>AMS</td>
<td>Activity Management System</td>
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<tr>
<td>CAC</td>
<td>Central Asia Crisis</td>
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<tr>
<td>CAP</td>
<td>Consolidated Appeal Process</td>
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<tr>
<td>CAR</td>
<td>Central Asian Republics</td>
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<tr>
<td>CCA</td>
<td>Country Common Assessment</td>
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<tr>
<td>CEPREDENAC</td>
<td>Coordination Center for Natural Disaster Prevention in Central America</td>
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<tr>
<td>CHAP</td>
<td>Common Humanitarian Action Plan</td>
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<tr>
<td>CNE</td>
<td>Costa Rica National Risk Prevention and Emergency Commission</td>
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<tr>
<td>CRED</td>
<td>Centre for Research in the Epidemiology Disasters</td>
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<tr>
<td>CRID</td>
<td>Regional Disaster Information Center</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<tr>
<td>DG</td>
<td>Director-General</td>
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<tr>
<td>DGO</td>
<td>Director-General’s Office</td>
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<tr>
<td>DOT</td>
<td>Directly Observed Treatment</td>
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<tr>
<td>DPRK</td>
<td>Democratic People’s Republic of Korea</td>
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<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
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<tr>
<td>ECHO</td>
<td>European Community Humanitarian Office</td>
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<tr>
<td>ECMI</td>
<td>European Centre for Minority Issues</td>
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<tr>
<td>ECOSOC</td>
<td>Economic &amp; Social Council, Humanitarian Affairs Segment</td>
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<tr>
<td>EFCT</td>
<td>Effective Field Coordination Training</td>
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<tr>
<td>EGB/GPR</td>
<td>External Relations and Governing Bodies/Government and Private Sector Relations</td>
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<tr>
<td>EHA</td>
<td>Emergency and Humanitarian Action</td>
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<tr>
<td>EHC</td>
<td>Emergency Health Intelligence and Capacity Building</td>
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<td>EHLK</td>
<td>Emergency Health Library Kit</td>
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<tr>
<td>EM-DAT</td>
<td>Emergency Events Database</td>
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<tr>
<td>EMRO</td>
<td>Regional Office for Eastern Mediterranean</td>
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<tr>
<td>EURO</td>
<td>Regional Office for Europe</td>
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<tr>
<td>EWARN</td>
<td>Early Warning</td>
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<tr>
<td>FYROM</td>
<td>Former Yugoslav Republic of Macedonia</td>
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<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunizations</td>
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<tr>
<td>HBP</td>
<td>Health as Bridge for Peace</td>
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<tr>
<td>HELID</td>
<td>Health Library for Disasters</td>
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<td>HELP</td>
<td>Health Emergencies in Large Populations</td>
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<td>HINAP</td>
<td>Health Intelligence Network for Advanced Planning</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immune-Deficiency Syndrome</td>
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<tr>
<td>HOAI</td>
<td>Horn of Africa Initiative</td>
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<td>HQ</td>
<td>Headquarters</td>
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<tr>
<td>IACNDN</td>
<td>Inter American Committee for Natural Disaster Reduction</td>
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<td>IASC</td>
<td>Inter-Agency Standing Committee</td>
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<tr>
<td>ICRC</td>
<td>International Committee of the Red Cross</td>
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<tr>
<td>IDP</td>
<td>Internally Displaced Person</td>
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IFRC  International Federation of Red Cross and Red Crescent Societies
IGAD  Inter-Governmental Authority for Development
IHA  Interim Health Authority
IHE  International Health Exchange
IHTF  Inter-Agency Health Task Force
IOM  International Organization for Migration
IMCH  Integrated Mother and Child Illnesses
IRC  International Rescue Committee
ISDR  International Strategy for Disaster Reduction
JICWELS  Japan International Corporation of Welfare Services
KFOR  Kosovo Force
LSS  Logistic Support Systems
LTTE  Liberation Tigers of Tamil Eelam
MBC  Mediterranean Council for Burns and Fire Disasters
MCDU  Military and Civil Defence Unit
MOH  Ministry of Health
MOPH  Ministry of Public Health
MOSS  Minimum Operational Security Standards
MSF  Medicins sans Frontières
NGO  Non-Governmental Organization
NID  National Immunization Day
OAS  Organization of American States
OCHA  Office for the Coordination of Humanitarian Affairs
OFDA  Office of United States Foreign Disaster Assistance
PAHO  Regional Office for the Americas – Pan American Health Organization
PED  Emergency Preparedness and Disaster Relief Co-ordination
PHC  Primary Health Care
PTC  Panafrican Emergency Training Centre
RISEM  Regional Information System for Emergency Management
SADC  Southern Africa Development Community
SEARO  Regional Office for South-East Asia
STAP  Special Technical Assistance Programme
STD  Sexually-Transmitted Diseases
SUMA  Supply Management
TB  Tuberculosis
UN  United Nations
UNAIDS  United Nations Programme on HIV/AIDS
UNCAP  United Nations Consolidated Appeal Process
UNCT  United Nations Country Team
UNDAC  United Nations Disaster Assessment and Coordination
UNDAF  United Nations Development Assistance Framework
UNDMTP  United Nations Disaster Management Training Programme
UNDP  United Nations Development Programme
UNFPA  United Nations Population Fund
UNHIC  United Nations Humanitarian Information Centre
UNHCR  United Nations High Commissioner for Refugees
UNHRD  United Nations Humanitarian Response Depot
UNICEF  United Nations Children’s Fund
UNJLC  United Nations Joint Logistic Centre
UNTAET  United Nations Transitional Administration for East Timor
USD  United States Dollars
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
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<tbody>
<tr>
<td>VAB</td>
<td>Vaccines and Biologicals</td>
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<tr>
<td>WFP</td>
<td>World Food Programme</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WPRO</td>
<td>Regional Office for Western Pacific</td>
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<tr>
<td>WR</td>
<td>WHO Representative</td>
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