Logistical Support Systems in Humanitarian Assistance
by Claude de Ville de Goyet

In the aftermath of disasters, one acute priority is to ensure that the right relief items arrive at the right place at the right time. In practice, more than to acquire supplies, the main challenge to the local humanitarian actors is to manage the flow of incoming supplies and sorting out the essential items from the inappropriate donations. More often than not, the authorities have little information on who received what and where it went. This scenario calls for the establishment of a global Logistical Support System (LSS). The needs are twofold:

- In each emergency, a software system is required to serve as a common data warehouse where logistic information on all humanitarian supplies at hand or in the pipeline is compiled, processed and disseminated. This component fulfills a coordination-information sharing function and therefore contributes to overall transparency of the assistance, a concern dear to the donor community.
- In a wider context, a Global LSS must also contribute to improving and strengthening the skills and tools of local agencies for the internal management of their own supplies. Stock management and inventory control, in particular, are not the most familiar concepts to the health sector. This technical cooperation and training component fulfills a local capacity building function.

The question is now: Why the health sector and WHO should play a lead role?

The Health sector has a major role in humanitarian assistance. Indeed, the entire humanitarian effort is motivated by concerns for the health and welfare of the victims. To play this leading role in response, the health sector should be one of the most fervent supporters of an efficient management that, in turn, cannot take place without logistical information and support. In the same extent that specialists in large hospitals are powerless in the absence of an army of maintenance engineers, technicians and support staff, health humanitarian teams, be it national or expatriate, are totally dependent on a flow of specialized supplies and equipment.

Although in dollar value and gross weight, food may represent the bulk of the logistic flow, the most complex and operationally urgent logistic problems are in the health sector. While the layman may easily identify and classify food and shelter commodities, the variety and diversity of medicines and medico-surgical equipment in humanitarian operations require the logistical expertise of health experts for any useful inventory.

Furthermore, unsolicited donations are a recurrent curse in almost all emergencies. While non-health donations may merely constitute a logistical nuisance by competing for scarce storage and transportation resources, inappropriate medicines and medical donations represent a definite public health risk and economic burden for the health sector. There have been instances when national health authorities had to appeal for external assistance to cover the needs of disposing of unwanted donated drugs.

Finally, in line with the basic principle for the core functions of WHO, the Organization has a comparative advantage in this field with its successful experience with SUMA, a LSS system in application in the Americas for over 10 years. These factors prompted WHO to accept the lead role in promoting a Logistical Support System based on SUMA®.

Once fully funded, the project will benefit the health sector in several ways:

- Collecting and sharing logistical information will improve the efficiency, transparency and accountability of the procurement and distribution of the health related supplies in emergency situations. The provision of health care to victims will improve through reduction of duplications and gaps in the procurement system.
- Sectorial coordination and leadership by the Ministry of Health (MOH) will be enhanced domestically and internationally through the net of contacts established with all humanitarian actors. By being a key actor in a multi-sectoral initiative, the MOH will strengthen its negotiating stand within the Civil Protection or National Disaster Committee.
- The preparatory process itself will improve the managerial and logistics skills of health professionals with immediate benefits for daily management activities.
Additional information on the global LSS project, based on the SUMA experience, is available at: [www.who.int/disasters](http://www.who.int/disasters).

*(Endnotes)*

1 A tool developed by PAHO for consolidated inventory and management of all humanitarian supplies and successfully adopted by the countries of this region. See page 4 of this issue.

**Bridge Building With A Difference: Coordinating Humanitarian Logistics in Afghanistan with the United Nations Joint Logistics Centre (UNJLC)**

In the current operation in Afghanistan amidst the myriad agencies, each with a specific mandate and resultant aim, there are key overarching strategic goals, vital to all. Bottlenecks must be fixed, flights must be deconflicted, seasonal inaccessibility must be mitigated: a logistics structure must be pertinent to the needs of all. It was for these reasons that the United Nations created a Joint Logistics Centre. Set up specifically to establish coherence amongst the logistics activities of the UN family (and those it interacts with), the UNJLC is not an agency but an inter-agency flying column able to be dispatched with little notice to bolster and structure UN operations in a specific emergency.

UNJLC has no large stockpile of logistical assets. You won’t see UNJLC trucks carrying goods, or UNJLC planes transporting cargo. Rather, what UNJLC provides is the ability to view the situation holistically, from a strategic level. Unfettered by day-to-day operational requirements, or the burden of a preexisting agency-specific mandate, UNJLC can focus on the priorities affecting the entire humanitarian community and coordinate the assets of others to promote a coherent and consistent response that benefits the aid effort as a whole.

The idea of a UNJLC was developed back in 1996 by WFP’s Logistics Chief David Kaatrud. Since then, UNJLCs have operated on a small scale in the Somalian floods, Kosovo, East Timor, the Gujarat earthquake, and DR Congo.

The operations in Afghanistan have illustrated the truly inter-agency nature of UNJLC. Since the Inter-Agency Standing Committee (IASC) in March 2002, the UNJLC has been recognised as a permanent part of the United Nations humanitarian response structure, under the aegis of WFP. In Afghanistan, staff are seconded from WFP, IOM, OCHA, UNHCR, UNICEF and WHO, displaying a diverse range of experience from the UN to NGOs to the Military. Part of the success of UNJLC is based on its inter-agency composition. Its varied make up means that it possesses a unique ability to effectively liaise with the many facets of the humanitarian community in Afghanistan.

UNJLC’s activities in Afghanistan cover a broad spectrum. UNJLC took responsibility for the coordination of both military and civilian cargo flights to and within the region. In the period that air operations ran, from November 2001 to June 2002, UNJLC managed to fly 1609 tonnes of humanitarian cargo into the region for a total of no less than seventeen different agencies and organisations. To this was added the airlifting of 2772 tonnes of goods on behalf of twenty-eight UN Agencies, NGOs and Embassies. Operations ended in June of this year but UNJLC remains ready to resume this role.

The value of UNJLC is best illustrated by its current efforts to ensure a joint winterisation strategy for the humanitarian community. From October onwards the bitter Afghan winter cuts off large parts of the country from outside help. It is imperative that aid be pre-positioned with the beneficiaries prior to the closure of the passes. UNJLC responded by organising a Winterisation Workshop in Kabul involving UN agencies, International Organisations and NGOs, the outcome of which was a strategy detailing requirements for the provision of aid for the winter period. Further details were collected through the Road Task Force meetings which UNJLC host at the sub offices in Herat, Kandahar and Mazar-e Sharif. The final link came in the form of a Donor Conference at which the plan was presented and UNJLC began the process of matching Donors with Implementing Partners.

The flexibility of UNJLC and its ability to mould itself to the specifics of each emergency has been proven in Afghanistan by its response to the politicised nature of the crisis. UNJLC successfully ensured the smooth running of the logistical aspects of June’s Loya Jirga elections. In addition to planning the deliveries of hardware such as tents and furniture to the regional election centres, UNJLC experts, supported the Loya Jirga Commission for the transportation of candidates from regional centres to the capital. ‘We were able to fly a total of 1153 candidates from all over Afghanistan to take part in the third phase of the Loya Jirga in Kabul in just two days’ comments Wilfried de Brouwer, consultant to UNJLC. ‘And once the elections had taken place, we did it all again in reverse.’

This willingness and ability to embrace all logistical aspects of the humanitarian effort is seen also in the inclusion of CMCOORD, or Civil Military Coordination, officers within UNJLC’s structure. The existence of a CMCOORD function in each UNJLC office, as well as a representative positioned in Coalition Central Command in Tampa, bridged the gap between the humanitarian community and the Military, helping to fit the specific aptitudes of the Military to the needs of the aid agencies. UNJLC is now responsible for making formal requests on behalf of the humanitarian community for assistance from the Coalition and ISAF.

The Afghanistan operation also sees the growth of a
Delivering essentials for public health

The United Nations Humanitarian Response Depot (UNHRD), “the Brindisi warehouse”, is a facility funded by the Italian Government and managed by WFP to provide storage and logistic support for both programme and operational supplies for UN humanitarian agencies and NGO’s.

In 2001, WHO, in collaboration with WFP and the Italian Government, utilised this facility 18 times, and delivered a total of 106 standard health kits into six different theatres of emergency.

consolidated information platform. ‘The plan is to forewarn and forearm the humanitarian community’ says Terri Toyota, head of UNJLC’s Kabul office, ‘by providing a collation of all the invaluable information scattered amongst the various agencies, and also through primary information we collect direct from our field coordinators ourselves.’ A key success in this regard was the commissioning of assessments of all major roads inside Afghanistan. It is hoped that by making this information available to Implementing Partners, Donors and Afghan Ministries, there will be information to effectively carry out rehabilitation projects and benchmark standards of implementation.

While operations continue in Afghanistan, an equal effort is being made in WFP- Rome to ensure that UNJLCs can be launched whenever and wherever required. Special ‘Fly Away’ kits are being prepared containing all the equipment necessary for an instant deployment of a UNJLC, and the process of analysing the lessons of Afghanistan has already begun. As Kaatrud says, ‘Afghanistan has been a great success for the UNJLC concept, with lessons learned and best practices derived from ten months of operations. We are now in an even stronger position to bring quick and effective coordination to an emergency environment of equal or greater complexity.’

More details on UNJLC’s operations in Afghanistan from the web site: www.unjlc.org.

This article was contributed by Matthew Dee, UNJLC Information Officer in Islamabad.

Preparing for effective response

The ultimate goal of humanitarian assistance is to reduce the avoidable burden of death and disease. Each disaster is unique in its manifestations but there is a correlation between the type of disaster and its effects on the health of the population. This concept is the key to preparedness. Logistics is the common point in all activities for any project, from dispensary rehabilitation, to drug supply systems, surveillance systems, vaccination campaigns, etc. Nevertheless it remains widely unknown in its daily management.

Deliverables: WHO has developed a set of health kits to provide supplies during emergencies. The kits are designed as ready-to-ship packages to allow a large-scale intervention anywhere, at any time. The most requested kit is the New Emergency Health Kit (NEHK). It provides essential drugs and medical supplies for 10,000 people for approximately 3 months. Due to the variety of causes of death and ill-health in emergencies, WHO has also developed several different types of kits (e.g. trauma, diarrhoea, etc.). The kits are prepared in advance and stored for deployment in emergencies. WHO established a close working relationship with the United Nations Humanitarian Response Depot (UNHRD) in Brindisi for the stockpiling of the kits. Being prepared in this manner, WHO can respond to a request with a minimum of time, plan its purchases and reduce the cost, and join other UN bodies in the set up of response systems.

Systems: Humanitarian logistics cannot be improvised in an ongoing emergency, it requires that procedure and framework are already in place. The logistic team is made up of purchasers, negotiators, supply systems experts, IT specialists, civil engineers, etc. Logistics are about planning, negotiating prices, consistent contacts with shipping companies, quoting new equipment for new locations, establishing maintenance procedures, etc. These actions must take place year-round to ensure prompt and efficient response when emergencies occur. A logistic system is efficient when it is able to provide an adequate response within a minimum time lag.

Partnerships: Following the same idea of a common effort to respond and reduce costs, WHO contributes to the UNJLC. WHO supported UNJLC Afghanistan by sending two logistic support systems specialists and a logistic field coordinator. In setting up flexible, coordinated systems, logistics prepare the way to better response.

For further information please contact H. Boucenine at: boucenineh@who.int

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<th>The growing distribution of New Emergency Health Kits</th>
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Number of operations NEHK from UNHRD

For further information please contact H. Boucenine at: boucenineh@who.int

This article was contributed by Matthew Dee, UNJLC Information Officer in Islamabad.
SUMA Decennial (1992-2002)

The SUMA project, an information tool for the management of humanitarian supplies from PAHO/WHO, was initiated officially in 1992 as a successful effort originating from various countries in Latin America and the Caribbean. The project was developed with financial support from the Netherlands, England, the United States, Canada, Germany and the European Community Humanitarian Aid Office (ECHO).

Since its start, more than 3000 volunteers have been trained in the application of the SUMA software and the integral logistical management of relief supplies. In various countries national SUMA teams have been formed, consisting of a multi-disciplinary and inter-agency group of (logistical) experts, to be mobilized in disaster situations. SUMA teams from neighbouring countries, when necessary, help to supplement the national efforts.

Ten years down the road, this effort has built a critical mass of dedicated supporters for an integrated and professional approach in the management of supplies. Consequently, the need for a national policy on the management of donations, including medicines, has received the attention of the highest authorities (presidency, foreign affairs, legislative bodies, etc…) in Latin America. SUMA has been recognized as the standard tool in the majority of the countries in the region of the Americas and has been used in all major disaster events in the region. It has evolved into a tool to improve transparency and accountability in times of disaster. The very use of SUMA is in fact an indicator of good emergency management. Currently, only some 15% of all donated goods in Latin America do not pass through the SUMA system.

A recent independent external evaluation which looked at the use of SUMA during the earthquakes on January 13 and February 13, 2001 in El Salvador, had very positive findings. Some of those conclusions were that SUMA is the only widely accepted system in the Latin American and Caribbean region for helping to manage humanitarian assistance supplies. Almost all the humanitarian assistance that arrived by air (90%) or that was purchased by, or destined for, the government of El Salvador was registered by SUMA.

Further, the report says that SUMA was an important element in strengthening El Salvador’s national capacity for managing humanitarian assistance and that it plays a clear role in transparency and accountability.

To read more on the final conclusions, recommendations and more details, please see the complete version of the report at the SUMA Web site: www.disaster.info.desastres.net/SUMA/eng/news.htm

For further information about SUMA please visit either the WHO/PAHO web site at: www.paho.org or the WHO/EHA web site at: www.who.int/disasters

On average, of funds requested for CAP 2002 proposals, the supplies component was 37%. Medical and other supplies (excluding vehicles) comprised 35% and IT approximately 2%.

WHO, August 2002
Humanitarian Assistance in Emergencies
A Guide for Effective Aid on Humanitarian Supplies Management

Many large-scale emergencies attract broad coverage by the international media and images of death and destruction circulate the globe in a matter of minutes. In the face of emergencies there is a natural human impulse to reach out and help those in need. International humanitarian relief efforts may greatly benefit from donations of appropriate items.

At times though, media images can be out of proportion with the actual situation at the disaster site. Often, emotional appeals for massive humanitarian assistance are issued without guidance on the priority needs. There are many examples of donations which cause problems instead of being helpful.

REMEMBER:

General Management and Co-ordination of Donations
- All donations should benefit the recipient and should respect the wishes and authority of the recipient. Ensure effective communication between the donor and the recipient, including consultation with the affected country’s relief services for information about needs.
- Most relief items can be purchased locally or in neighbouring countries. It is more economical, convenient and safe to purchase items locally than to ship used items.
- A disaster is not likely to cause a national food shortage although the international media may highlight local distribution problems. If food is requested, it must be non-perishable, clearly labelled, and appropriate to the local culture.
- Assist countries during the preparedness, rehabilitation, and reconstruction phases. An affected country will deplete its financial and material resources when responding to the immediate effects of a disaster. Donors should invest in long-term projects aimed at reconstruction and reducing vulnerability to future disasters.
- Co-ordinate the efforts of independent assessment teams or fact-finding missions with those of the affected country and other agencies.

Medicines, Medical Supplies & External Medical Teams
- Pharmaceutical products take up needed space and divert the attention of medical personnel from other more pressing tasks to sort, classify, and label them.
- Blood and blood derivatives: there is much less need for blood that the public commonly believes. This type of donation is unsuitable because it requires quality and safety controls, such as refrigeration or screening for detection of HIV antibodies.
- Field hospitals, modular medical units: this type of equipment is justified only when it meets medium-term needs and it should not be accepted unless it is donated. Equipment specifications such as weight, volume, freight and installation costs should be transmitted to Ministry of Health authorities so that they can determine its usefulness.
- Clearly differentiate between the immediate life-saving needs for search, rescue and emergency medical care on the one hand, and the type of health assistance required for longer-term rehabilitation on the other. Each requires a distinct policy and strategic approach.
- Usually, the local health services are able to handle emergency medical care to disaster victims. If international aid is needed, neighbouring countries are in the best position to assist during the immediate aftermath of an event. Highly skilled specialists who have been specifically requested by the Ministry of Health are an exception.
- Lack of medical attention to disaster victims is often caused by logistics problems, rather than by lack of medical volunteers. In that case, external medical teams will only compound the problem.
- Offer or accept only medical volunteers and teams sponsored by a well-known agency that can vouch for their qualifications and are familiar with the language, culture, and level of technology appropriate to the situation.

Preparing, Dispatching & Receiving supplies
- Prepare a packing list describing the contents, ideally broken down by parcel. Insert the packing list in one of the parcels and mark it “Packing List.” Protect that list inside a water-resistant envelope.
- Make parcels of a weight, size, and shape that can be handled by one person (between 25 kg - 50 kg maximum) and pack supplies in separate parcels according to their nature (drugs, food, personal needs, etc.). Label visibly every parcel with the name, address and telephone number of the sender and the consignee, and any other specific characteristics of the cargo: fragile, urgent, need refrigeration, etc.
- Inform consignees about the dispatch of every single shipment. Include information about the consignment (packing list, number of parcels, etc.), the means by which it was sent (type, company, characteristics, person in charge, etc.), its exact destination, arrival point and estimated time of arrival.
- Don't send any supplies that have not been requested by the disaster-stricken country. Don't clog relief channels with donations that are not urgently needed.

Sources:
The do’s and don’ts of Humanitarian Supplies Management, Offers and Request for External Medical Teams
Excerpt from: Humanitarian Assistance in Disaster Situations
Pan American Health Organization (PAHO)
Guidelines for Drug Donation
World Health Organization (WHO)
MOSS AND WHO

Humanitarian work can be dangerous. 216 United Nations civilian staff lost their lives between January 1992 and September 2002. An additional 265 were kidnapped or taken hostage since January 1994. All staff serving at high-risk duty stations must be trained and briefed regarding their basic security.

The United Nations Secretary General has taken a personal interest in and is fully committed to the safety and security of staff. He has indicated this in many statements, notably, “There should be nothing discretionary about the financing of staff security: it is neither a luxury nor a perk.”

The UN Secretary General has established new standards under which all UN staff (international and national) will be required to operate: the Minimum Operating Security Standards (MOSS).

MOSS came into effect two years ago and must be implemented by January 2003. This has considerable implications for WHO. Henceforth, all staff members must:

- Receive induction briefings and training on:
  - Personal security
  - Hostage survival
  - Office/residential security
  - Use of communication equipment
  - Basic first aid
  - Mine awareness

- Be certified as having received security training before being deployed to a high-risk duty station (those already in the field will be required to participate in security certification courses in-country).

- Have responsibilities for security incorporated into their job descriptions.

- Be given the means of accessing a 24 hour security telecommunications centre whilst in the operational area.

The above will require the mobilization of considerable budgetary resources, capacity building and training. Although the intent is that these resources be found within the regular budget, managers should be aware of all the components of MOSS and incorporate them in the budgets of present and future projects. For example: satellite phones, radio networks, flack jackets, first aid kits and other items may be required according to the security phase in any given country. Furthermore, as the security phase may change, each budget should be flexible enough to provide additional equipment as necessary.

Given the immediacy of emergencies and the overwhelming pressure to deploy response staff to the field, managers may forget or be tempted to ignore MOSS. They do so at their peril: not only will uncertified staff be refused entry to the operational area, mechanisms to sanction managers responsible for attempting to deploy the staff member are under consideration.

In the field, if the standards for MOSS are not reached within a given time frame then UNSECOORD will have the responsibility of reporting deficient agencies to the UN Secretary General with a recommendation that the agencies operations be suspended as the security of staff is at risk due to inadequate security resources and procedures.

Operational Security Management in Violent Environments - ODI Good Practice Review 8 - by Koenraad van Brabant

With a primary audience of field-level managers responsible for security of staff and assets, this publication offers a step-by-step approach to security management starting from context analysis, threat and risk assessment through security strategy choice, to security planning. The book reviews major threats, preventative measures, and guidelines for survival and incident management. The importance of incident analysis and exchange of security information between agencies is explored, together with crosscutting themes such as personal and team competency, clarity towards national staff, good communications, briefing and training etc. The annexes provide additional information, on legal protection of aid workers, private security companies, the UN security management system, insurance cover etc. The arguments in this Good Practice Review are illustrated with case material drawn from all over the world.

More information can be obtained from hpn@odi.org.uk or www.odihrp.org.

What is the Tampere Convention?

The Tampere Convention is an international treaty that sets out the Provision of Telecommunication Resources for Disaster Mitigation and Relief Operations. It is the first treaty of its kind which attributes privileges and immunities to personnel of Non-governmental organizations and non-State entities with the prime aim of the removal of regulatory telecommunications barriers. The operational coordination is to be carried out by the United Nations Emergency Relief Coordinator (i.e. through the United Nations Office for the Coordination of Humanitarian Affairs, OCHA).

The full text of the Convention is available at: www.reliefweb.int/telecoms/tampere/icet98-e.doc.
A CRISIS CREATED BY THE LACK OF ACCESS

In the occupied Palestinian territory (oPt), the population is facing extremely difficult living conditions. 66.5% of the population live below the poverty line, more than 50% are experiencing a decreased food consumption, there are frequent outbreaks of diseases (e.g. 600 reported cases of Shigellosis), a 100% increase in home deliveries and 13.2% of children suffering from acute malnutrition. One primary reason that the living conditions are so hard is related to lack of access: the impossibility to get what is needed where it is needed.

The network of roadblocks and checkpoints of the Israeli Defense Force prevents or slows down the movements of Palestinians and humanitarian workers and isolates villages from one another. Curfews are imposed throughout the territories and their lifting remains sporadic and inadequately publicised, hampering the possibilities for humanitarian agencies and the civilian population to plan ahead. A statement released in July by the Association of International Development Agencies (AIDA) - the major international NGO coordination forum in the oPt – illustrates the difficulties faced by service providers. They stated that they could no longer fulfil their mandates due to excessive delays at military checkpoints, inconsistent refusal of access to project sites and beneficiaries, and harassment and severe restrictions on the movements of local and international staff. As a result of the logistic crisis of the Palestinian institutions and the difficulties experienced by the international agencies, relief activities are paralysed.

The World Health Organization together with the Palestinian Ministry of Health (MOH) and in collaboration with both the Italian Cooperation and USAID, set up the Health Inforum in Jerusalem, an operations room whose aim is to facilitate the information flow across the Palestinian health sector. Since local humanitarian workers could no longer bring supplies from one point of the territories to another, international staff use the platform of Health Inforum to inform on needs. Requests for help, both in terms of money and supplies, are communicated to the Health Inforum. The Health Inforum has become, among other things, the place to find innovative solutions in terms of logistics management. Lists of medicines are posted on the web site and all humanitarian partners then work to meet the needs. For example, convoys of medical supplies from the Ministry of Health warehouse to the villages from one another. Curfews are imposed throughout the territories and their lifting remains sporadic and inadequately publicised, hampering the possibilities for humanitarian agencies and the civilian population to plan ahead. A statement released in July by the Association of International Development Agencies (AIDA) - the major international NGO coordination forum in the oPt – illustrates the difficulties faced by service providers. They stated that they could no longer fulfil their mandates due to excessive delays at military checkpoints, inconsistent refusal of access to project sites and beneficiaries, and harassment and severe restrictions on the movements of local and international staff. As a result of the logistic crisis of the Palestinian institutions and the difficulties experienced by the international agencies, relief activities are paralysed.

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1. Information tools:
   - Comprehensive web site
   - Contact database and regional contact sheets
   - Physical and electronic maps of health care facilities in the West Bank & Gaza Strip
   - Activity overviews (who, what, where) for the donor community, international NGOs, UN agencies, and Palestinian NGOs
   - Health Inforum weekly newsletter (6 issues)
   - An alert mechanism for the rapid deployment of vehicles to assist with movement of essential medicines and supplies

2. Analysis
   - Matching requests for supplies with procurement activities
   - Health situation overview including a comprehensive framework of indicators and a preliminary index which can be used as an early warning system

3. Catalysing action within the health sector community
   - Linking actors working at the field level to facilitate delivery of essential medical supplies
   - Coordinating activities to discuss the “who, what, where” in the international NGO sector as well as priority areas for operation.
   - The Core Group on health has been activated to take a leading role in defining the scope of Health Inforum’s activities and in defining priority areas for the health sector.

different health institutions were organised by the ICRC; Ministry of Health officials were escorted by members of the Association of International Development Agencies; the World Food Program (WFP) implemented a large emergency convoy to move medical supplies from the Central Stores of the Ministry of Health to different cities of the West bank.

(Endnotes) 1 Health Inforum, previously known as HART (the Health Action Response Team) For further information please contact A. Manenti at: manentia@who.int

Latest edition of the PAHO newsletter focuses on logistical support systems

This month’s editorial in the PAHO newsletter, Disasters: Preparedness and Mitigation in the Americas-July 2002, focuses on logistical support systems as a new growth industry that has caught the attention of the private sector.

The newsletter is available at: www.phao.org/disasters
Learning Support Office for the Southern Africa Humanitarian Crisis

The Learning Support Office (LSO) project was initiated by ALNAP1 of which WHO is a member. WHO, with other international actors, will help set up a pilot LSO in Malawi to improve the quality of emergency response for the Southern Africa humanitarian crisis by promoting and facilitating field-based learning.

The LSO will explore how humanitarian action can be maximized through real-time, field based learning. The Office will provide a focus for sharing information and experiences between different humanitarian actors, provide easy access to references, tools and guidelines and enable lessons learnt to be compiled and shared locally and internationally. Scheduled to start functioning in Lilongwe, Malawi in October this year, it will be the LSO for all humanitarian actors, national and international, involved in the Southern African crisis.

The LSO aims at making a positive impact on the quality of emergency response in the field through the promotion and facilitation of three-way learning activities: i. ‘learning-in’ (providing key information, international standards & guidelines, lessons learnt from similar crisis elsewhere, funding mechanisms, etc); ii. ‘lateral learning’ (facilitating cross-organizational information and experience sharing); and, iii. ‘learning-out’ (managing, compiling and disseminating field learning that may be applied in other contexts). The LSO will provide a resource centre and access to electronic databases and web sites; establish newsletters and email links; conduct briefings, trainings and provide opportunities for discussion and mutual learning throughout the crisis.

The LSO will be run by three international staff recruited by ALNAP and five national staff. Through the Department of Emergency and Humanitarian Action, AFRO and WR Malawi, WHO has been involved in developing the project and is on the steering committee to oversee its implementation. The project will be supported by the WHO country office in Malawi. The WHO Regional Office for Africa (AFRO) will collaborate from the design to the implementation phases in order to maximize learning and response.

Public health is also continuous learning and teaching. The LSO provides an opportunity to strengthen the normative aspects of response by placing health at the center of the humanitarian action in the Southern Africa Humanitarian Crisis. It will help define health-driven strategies and provide opportunity for evidence based decision making for humanitarian action.

(Endnotes)

1 Established in 1997, the Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) is an international interagency forum. ALNAP’s statement of purpose: “ALNAP, as a unique sector-wide active-learning membership network, is dedicated to improving the quality and accountability of humanitarian action, by sharing lessons; identifying common problems; and, where appropriate, building consensus on approaches. For more information please contact: gamhewageg@who.int

The SPHERE Handbook in Arabic

The ARABIC VERSION of the Sphere Project Humanitarian Charter and Minimum Standards in Disaster Response has been produced. The Sphere Project recommends that copies be ordered from Dar Al-Shorouk in Amman or one of its branches or agents in Arab countries. They can be contacted at: shorokjo@nol.com.jo or through their web site at: www.shorok.com

Computer-Based Mass Casualty Management Training in Nepal

A successful computer-based mass casualty management training has just been completed in Kathmandu. During four weeks 150 health sector professionals from across the country alternated in two-day training sessions designed to develop the health sector’s capacity for casualty stabilisation, triage and disaster logistics.

Building on a pioneering training programme carried out in 2001 for 350 health sector staff, this year’s programme again used the software Multi-User System for Training Emergency Response (MUSTER). Simulations of an earthquake and an air crash, relevant to the Nepalese and Asian context, were combined with presentations and mock debriefings. A dynamic virtual world addressing both individual capacities and team skills created a stimulating learning environment for triage techniques and pre-hospital management of victims.

Collaboration with the Ministry of Health, the National Society for Earthquake Technology - Nepal, the Nepal Red Cross Society and Kathmandu Medical College strengthened the programme and has ensured the sustainability of this highly effective training within Nepal. WHO Nepal has the user-rights to the computer software and would be happy to facilitate its use throughout the South-East Asian Region.

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Application of ETAT guidelines in humanitarian emergencies

In emergency settings, children are at increased risk usually due to common preventable illnesses such as diarrhoea, acute respiratory infections, malaria, measles and malnutrition. In such situations, children are likely to be ill more frequently and more severely because of their increased susceptibility, underlying malnutrition, lack of family care leading to delayed care-seeking, dehydration and lack of appropriate food. In emergency settings those delivering health care often come from widely varying backgrounds, and there are few standardized guidelines. Therefore, WHO’s department of Child and Adolescent Health and Development (CAH) has developed guidelines on IMCI (integrated management of childhood illness) and ETAT (emergency triaging, assessment and treatment) for use in such situations.

Guidelines for ETAT were developed to improve the emergency assessment and treatment of sick children on their arrival to a health facility, including appropriate identification of cases that need priority treatment, so as to increase the speed of emergency interventions. The application of ETAT requires reorganisation of staffing and flow of patients in the health facility. Two validation studies were carried out in Brazil and Malawi in hospitals with a large turnover of emergency visits. The performance of health workers who used the ETAT algorithm to identify children with priority signs was compared with assessments by a paediatrician trained in the Advanced Paediatric Life Support system. The results indicated that triage using the algorithm can be carried out very quickly (10-20 seconds) when the sick child shows no priority signs, and that the guidelines are suitable for triage of all sick children on their arrival to a health facility. The ETAT protocols were also pretested in refugee camps in Kigoma, in the United Republic of Tanzania, where ETAT training followed training in IMCI for outpatient care.

The participants first learn the emergency signs and how to recognize them, then learn the flow of the assessment and treatment, appropriate treatments and how to do them, and finally reach proficiency in the entire process of assessing and treating a child quickly.

A baseline assessment of the quality of health care in Kigoma camp was conducted in April 1999, prior to the introduction of the IMCI and ETAT training programme. A second assessment conducted in November 1999, reported the following conclusions:

- The training of health workers in IMCI and ETAT guidelines can improve the quality of care in refugee camp health facilities.
- In a situation where several independent organizations are providing health care, there are advantages in having common standards for clinical care. This standardization can be used as the basis for shared training, supervision, monitoring and evaluation. It can also facilitate sharing of staff between organizations without compromising the quality of care.

- Standard treatment schedules offer the possibility of savings and simplification in the supply of drugs and equipment.
- Because IMCI is being increasingly and widely used, training in IMCI provides refugee health workers with a skill that is likely to be useful when they return to their home countries.

In conclusion, the findings of the assessment missions carried out by UNHCR, UNICEF, WHO and Ministry of Health Tanzania are that this approach has lead to improved quality of care and more efficient organization of services in a stable refugee setting. The Kigoma experience also demonstrated the value of standard clinical procedures that help the health worker to detect all major conditions in a child presenting for care and provide guidance on simple treatments. These benefits can apply in any emergency setting. WHO/CAH is in the process of finalizing the interactive training material on ETAT to make it available for humanitarian emergency settings.

(Endnotes)


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New Disaster Preparedness and Response Web Site

The Disaster Preparedness and Response programme (DPR) of the WHO European Region has a new web site. The address is: www.euro.who.int/emergencies. Here, you can find information about the DPR programme, field activities, technical guidance, and newsletters.

Contact Jeff Lazarus at jla@who.dk for further information or to contribute content.
**World Health News**

**EHA Induction Briefing**

Seventeen health professionals from WHO and partner agencies attended the 4th WHO Induction Briefing on Emergency Preparedness and Response in July 2002.

The Induction Briefing is a five-day course on WHO’s visions, strategies and services for emergency preparedness and response. It is conducted on a regular basis by the Department of Emergency and Humanitarian Action. Learning is facilitated by sharing of experiences, case studies and information/teaching sessions. The Briefings involve resource persons from EHA, other WHO technical departments, other UN agencies (UNHCR, OCHA) as well as other partners (IFRC, IOM, MSF, etc.).

WHO Country Representatives, Liaison Officers and EHA focal points based in the Republic of Congo, Sierra Leone, Uganda, Liberia, Colombia, Djibouti, Syria, Sudan, Georgia, FYRO Macedonia, Indonesia, Papua New Guinea, Viet Nam and Guineé attended the course together with one participant from UNFPA and one each from two donor agencies, DFID and USAID.

Nearly 50 participants have undergone this briefing in the past year. In July, all the participants rated the course positively with over two thirds awarding the highest possible rating of “Very good”. By the end of the course more than 4 out of 5 participants said they were confident to apply what was learnt in the Briefing to their work with 1 in 2 claiming they felt “very confident” to do so. All of the participants would recommend the course to colleagues with nearly 2 out of 3 saying they were very likely to do so. Two thirds of the participants said the length of the course was just right, 1 in 4 said it was too long and one participant said that the course was too short. More than three-quarters of the participants rated the materials as “useful” or “very useful”.

Some of the suggestions for improving the Briefing listed by participants were to increase the time for discussion and for resource persons from Technical Departments in WHO to stay focused on their services for emergencies.

WHO will conduct the next Induction Briefing from 11-15 November 2002.

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**Workshop on the 2002-2003 Plan of Action for HIV/AIDS in Emergency Settings**

On 10-11 September, the IASC Reference Group on HIV/AIDS in Emergency Settings conducted a workshop to agree on a detailed plan of action for 2002-2003. The aim of the workshop was to: “Identify what we want to achieve and how we will achieve it.”

At the end of 2001, over 70 countries from different regions experienced emergency situations, resulting in over 50 million affected persons worldwide. Many are exposed to conflict, social instability, poverty and powerlessness that also favour the rapid spread of HIV/AIDS and sexually transmitted infections.

The Working Group of the Inter-Agency Standing Committee (IASC WG) created a Reference Group on HIV/AIDS in Emergency Settings to address the growing interest and activity by agencies and organisations in prevention and care in HIV/AIDS in emergency settings, as well as the need to ensure best practice and coordination. The Reference Group is chaired by WHO, and its members include: Civil and Military Alliance (CMA), FAO, The International Centre for Migration and Health (ICMH), ICRC, ICVA, IFRC, IOM, OCHA, UNAIDS, UNDP, UNFPA, UNHCR, UNICEF and WFP.

*For a report of the workshop please contact L. Kuppens at kuppensl@who.int*

**International Conference on the Determinants of Survival and Health in Emergencies.**

WHO is organising an international conference on the determinants and impact of emergencies on health service delivery and on the health status of affected populations. The conference will be held in February 2003 (venue to be determined). Two main themes will be discussed: 1) the impact of chronic and recurring emergencies on health delivery systems and on people’s health status, and 2) the different data collection, analysis and decision-making tools and methods used for assessing risks and needs for health emergency management. The conference targets health managers and professionals involved in health coordination and decision making at field or country levels. The next issue of Health in Emergencies, due in December 2002, will present the agenda of the event and background documents.

*For more information, please visit www.who.int/disasters or contact either A. Colombo at colomboa@who.int or T. Sleeuwenhoek at sleeuwenhoekt@who.int*

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**What the participants wrote about the Briefing:**

- It was the best training I have been to in WHO.
- The atmosphere was just right... made learning easy.
- The resource persons had good knowledge and skills.
- Thanks for inviting me. I found it (the course) very useful!
- It is difficult to improve the Briefing. The whole process was excellent.
SMART: Monitoring humanitarian assistance

USAID convened a workshop in Washington in July to review the progress of their initiative towards improvement in the monitoring, reporting and evaluation of humanitarian assistance. The workshop saw the participation of 45 agencies. There was consensus that mortality rate and nutritional status are the most basic, essential public health indicators for measuring the impact of a humanitarian crisis and the overall performance of the relief systems, even if they cannot be used for assessing the performance of any single organisation or intervention. To effectively support programme decisions, mortality and nutritional survey data must be interpreted within the general context of the crisis. In particular, food security information is essential for identifying the causes of malnutrition, for predicting trends and for making appropriate decisions. Methodological problems in survey design and conduct are common, not only in mortality studies (which are more prone to error) but also in nutritional assessments, where a validated methodology exists. Various recommendations were made: to promote triangulation of data derived from other sources and methods, to invest in training of agencies active in the field, to improve the standardization of methods, to set up an independent technical advisory group to review and accredit surveys results. Peer review was also suggested, with a central repository of survey data in the public domain. Donors were also encouraged to improve coordination in this domain by requesting that their implementing partners use the same standardized methodology whenever possible, and to adopt the same reporting format. With regards to mortality surveys, more operational research is required to test and validate new approaches recently proposed. Finally the value of surveillance in providing a dynamic picture of the crisis was reconfirmed.

For more detailed information and technical documents, see the SMART web page at: www.payson.tulane.edu/haresults

For further information about this article please contact S. Colombo at: colomboa@who.int

(Endnotes)

1 SMART (Standardised Monitoring and Assessment of Relief and Transitions) was launched by USAID and the US Department of State to promote the use and standardisation of nutritional and mortality indicators

2 NGOs, IGOs, UN, universities and representatives from donors and governments

Tools and References for Emergency Health Management

The WHO Tools and References for Emergency Health Management package is now available through the EHA web site. As access to the Internet is not guaranteed during emergencies, the tools have been also packaged on diskettes and CD-ROM to facilitate use, dissemination and field access.

The References section includes 1) a bibliography representing an initial attempt at gathering essential references related to emergency health preparedness and response from 1960 to the present; 2) Reference values, selected health indicators; 3) Technical Hazards sheets (drought, earthquake, floods, landslides, vegetation fires, volcanic eruptions); and 4) Web sites of interest.

The Tools section carries a range of ready-to-use templates: 1) Principles of engagement, coordination sample forms; 2) Situation reports, country reports, travel reports, technical donor report and health surveillance summary; 3) Planning tables for WHO’s Core Commitments in emergencies; and 4) Terms of reference.

The package will be continuously updated and expanded to serve the health information management needs in the field.

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Preparing for the CAP, 2003 Workshop in Sierra Leone

Many countries undergoing emergencies are organising workshops to prepare for the Consolidated Appeals of the next year.

The workshop in Sierra Leone was not standard as the country is moving towards a transition phase. This new context was addressed by linking medium and long-term national recovery strategies to the short-term humanitarian strategy. Being able to work with a group representing almost all the important stakeholders: Government officials - UN agencies, donor representatives, NGOs and CBOs - made for a rich process. The discussions on lessons learned, national and sub-regional perspective and the broader policy issues were quite productive.

Sierra Leone is one of the countries in West Africa where donors and implementing agencies are looking more closely at how the Common Humanitarian Action Plan (CHAP) can be formulated to make it more useful to monitor the progress in its implementation.

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