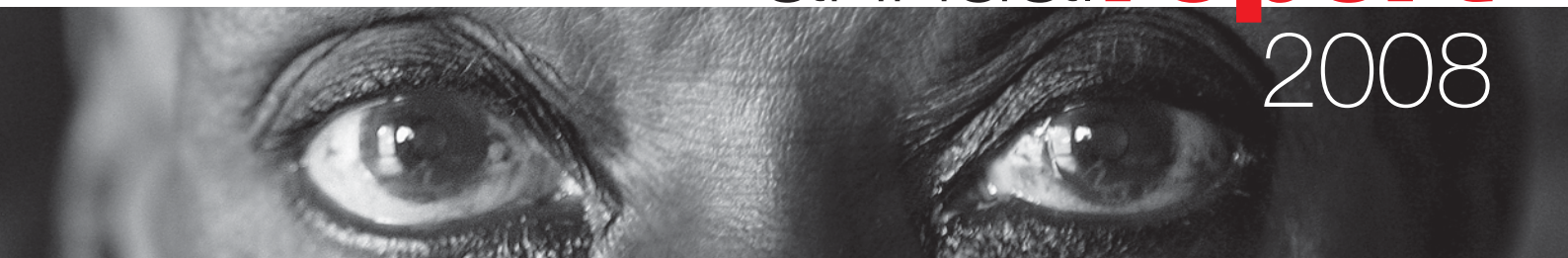


Health Action in Crises

Primary Health Care in Crises

annual **report**
2008



© World Health Organization, 2009

All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press, at the above address (fax: +41 22 791 4806; e-mail: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Acknowledgments

The HAC Annual Report 2008 was produced under the overall coordination of Giuseppe Annunziata (editor-in-chief).

Contributors (in the order in which the section appears in the document): Giuseppe Annunziata (Quantifying crises); Camille Pilon assisted by the Regional Offices (2008: continuing challenges); Xavier de Radiguès, Claudine Prudhon, Pierre Salignon (Improving mortality and nutrition data collection and analysis in crises); Erin Kenney (Using the cluster approach at country level to improve humanitarian health action); Michelle Gayer (Communicable disease control in humanitarian emergencies); Paul Garwood, Camille Pilon (Communicating health action in crises); Rudi Coninx (Staff competency: a critical element); Jon Carver, Liudmila Cheremukhina, Jules Pieters, Olex Babanin (Getting operational); Nicole Adler, Jukka Sailas (Funding for WHO's emergency work).

The Primary health care in crises section was produced by Giuseppe Annunziata and benefited greatly from the inputs and comments of the following people: Jonathan Abrahams, Samir Ben Yahmed, Olga Bornemitzka, Rayana Bouhaka, David Bradt, Francesco Checchi, Cristina Del Pueyo, Xavier de Radiguès, Cintia Diaz-Herrera, Richard Garfield, André Griekspoor, Omar Khatib, Daniel Lopez Acuña, Dudley McArdle, Abdelhay Mechbal, Roderico Ofrin, Heather Papowitz, Enrico Pavignani, Jonny Polonsky, Claudine Prudhon, Kumanan Rasanathan, Lynda Redwood Campbell, Chen Reis, Gerald Rockenschaub, Pierre Salignon, Luzitu Mbiyavanga Simao, Wim Van Lerberghe, Dana Van Alphen, Mark Van Ommeren, Nevio Zagaria, Ahmed Zouiten.

The report was edited by Paula Soper, assisted by Camille Pilon and Connie Calvert.

Design and layout: Steven Ewart

Graphs: Camille Pilon, Samuel Petragallo

Photographs: WHO/Marko Kocic (Cover and title page); IRIN/Siegfried Modola (p. iv); WHO/Madeleine Decker (p. 2); WHO/Paul Garwood (p. 7); IRIN/Allan Gichigi (p. 8); WHO/EURO (p. 9); Yu Yanyan (p. 12); WHO (p. 13); WHO/Ibrahima Fofana (p. 14); WHO/SEARO/Anubhar Das (p. 15); WHO/Michel Tomaszek (p. 16); WHO/Chris Black (p. 19); UNMIS/Tim McKulka (p. 20); WHO/Myanmar (p. 22).

Health Action in Crises

Foreword	1
<hr/>	
Quantifying crises	3
Natural disasters	4
Armed conflicts	5
Severe food insecurities	5
Population movements	5
A methodological challenge	6
<hr/>	
2008: continuing challenges	7
January–December	8–18
<hr/>	
Crisis issues	19
Improving mortality and nutrition data collection and analysis in crises	20
Using the cluster approach at country level to improve humanitarian health action	21
Communicable disease control in humanitarian emergencies	22
Communicating health action in crises	23
Staff competency: a critical element	23
Getting operational	24
Funding for WHO's emergency work	25
<hr/>	
Primary health care in crises	27
Voices from the field	28
PHC renewal: responding to the challenges of a changing world	29
Humanitarian crises: a continuous threat	29
Humanitarian health action as part of the PHC renewal: common principles and synergies	30
PHC renewal and humanitarian action: moving towards a rights-based approach	40
Concluding statement	40
<hr/>	
Way ahead	41
End notes and references	42



Ethiopia

Foreword

WHO's emergency work is often associated with flying in tons of humanitarian supplies and medicines to aid the survivors of high-profile disasters, dispatching emergency health experts to help save lives, and working with ministries of health to stave off public health threats during humanitarian crises.

While all this is true, it represents only the most visible part of our work. Throughout the year, WHO staff also work behind the scenes to help governments prepare for emergencies and put in place the kinds of resilient, sustainable, community-oriented health care services that can cater for all segments of the population before, during and after crises.

No one agency can address all the complex challenges posed by humanitarian crises. Humanitarian health action must be planned and implemented in close collaboration with partners in order to coordinate efforts, avoid duplication and fill gaps. In 2008, WHO, as lead agency of the Health Cluster, focused much of its efforts on introducing the cluster approach in several new countries. This has resulted in better coordination, enhanced health care delivery and greater joint efforts in many settings. WHO will continue to pursue the cluster objectives of coordinated action, strengthened accountability and greater predictability by expanding the cluster approach to new countries in 2009, in close collaboration with national authorities and local communities.

Humanitarian health action must be implemented in the field, where crises occur. WHO strengthened its emergency operational capacity in 2008 by expanding its humanitarian supply network and further developing its emergency standard operating procedures. These efforts have paid off: WHO was one of the few humanitarian agencies with an international presence in Myanmar and in Gaza during the acute phase of the emergency.

WHO is also strengthening and consolidating its overall logistics capacity. Health Action in Crises is working with other technical areas to pool operational resources and know-how into a common operational platform to support the Organization's response to various types of emergencies, from communicable disease outbreaks to natural disasters, from chemical incidents to complex crises.

Contributions for WHO's emergency work rose to their highest-ever levels in 2008, reflecting donors' increased trust in WHO. Equally, implementation kept pace with donations, indicating WHO's improved capacity to utilize emergency funds.

Primary health care (PHC) is the issue on which WHO has been providing global stewardship for decades. WHO has continued to be a strong advocate of the PHC approach, and has devoted its 2008 *World Health Report* to this important topic. Taking its inspiration from the 2008 *World Health Report*, the last part of the present report attempts to place PHC in a humanitarian context. People are at the core of the PHC approach just as they are at the centre of humanitarian health action. From Gaza to Goma, WHO has been helping health providers strengthen and consolidate the PHC approach in order to ensure that millions of people, particularly those in vulnerable settings, are able to cope and remain healthy when faced with crises.



Eric Laroche
Assistant Director-General
Health Action in Crises



Burundi

Quantifying crises

The need for systematic data collection about the magnitude and analysis of trends of natural and man-made disasters is an increasing concern of both development and humanitarian response agencies. However, data on disasters, their effect upon people and their cost to countries are currently not collected in a systematic and standardized fashion.¹ The recently-established Health and Nutrition Tracking Service will attempt to redress this situation by supporting quality measurement of key health indicators using appropriate, standardized measurement methods. In the meantime, and bearing in mind the above limitations, some current data on various humanitarian crises are presented in the following section.

Natural disasters

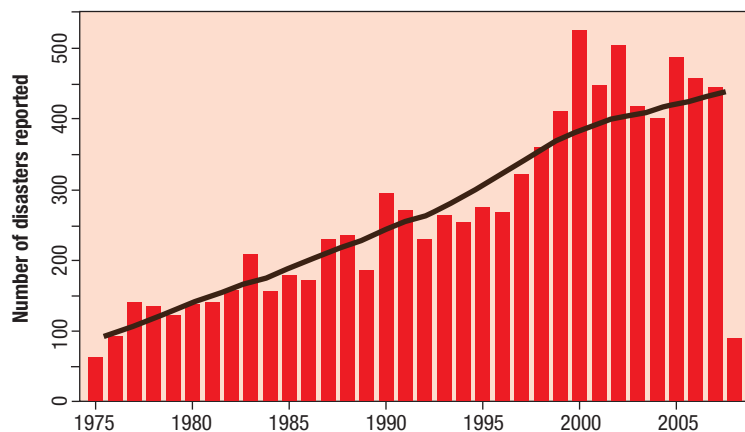
According to the Center for Research on Epidemiology of Disasters (CRED), the number of natural disasters in 2008 was 321 – below the annual average of 398 for 2000–2007.²

However, according to the same source, 2008 saw a marked increase in the number of deaths compared to the 2000–2007 yearly average. CRED calculates that natural disasters killed 235 816 people in 2008. This death toll – more than three times the annual average of 66 812 for 2000–2007 – was mainly caused by two major events: Cyclone Nargis which killed 138 366 people in Myanmar and the Sichuan earthquake in China which caused the deaths of 87 476 people.

Disaster costs in 2008 were twice the US\$ 81 billion annual average for 2000–2007, mainly due to the Sichuan earthquake in China (US\$ 85 billion) and Hurricane Ike in the United States of America (US\$ 30 billion).

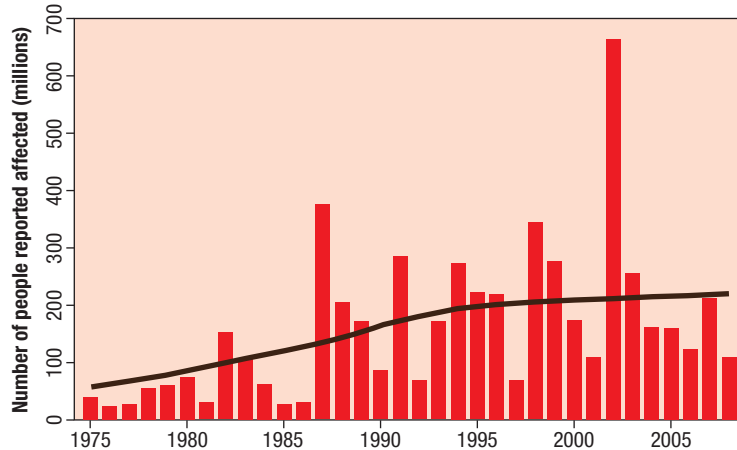
The number of people affected by disasters in 2008 was estimated at around 211 million, some 20 million less than the 2000–2007 annual average of 231 million. However, going back further in time, a review of the period from 1975 to June 2008 shows a steady increase in the number of people affected by natural disasters.

Natural disasters reported 1975–June 2008



EM-DAT: The OFDA/CRED International Disaster Database, (www.emdat.be), Université de Louvain, Brussels, Belgium

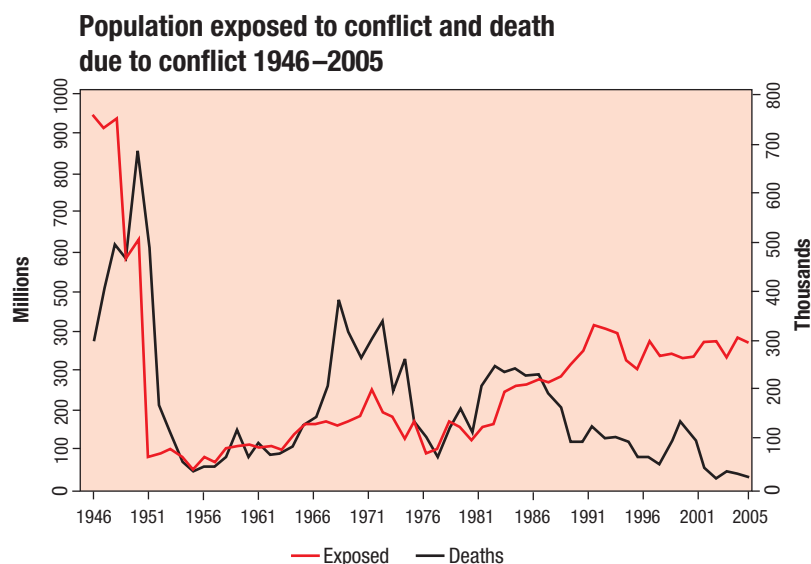
Number of people reported affected by natural disasters 1975–June 2008



EM-DAT: The OFDA/CRED International Disaster Database, (www.emdat.be), Université de Louvain, Brussels, Belgium

Armed conflicts

According to Uppsala University's Conflict Data Programme,³ there were 14 major armed conflicts in 13 locations around the world in 2007. In the past decade, the number of active major armed conflicts worldwide has declined overall, with major falls in 2002 and 2004 but an increase in 2005.⁴ The global number of people exposed to conflict decreased somewhat (although it remained at comparatively high levels historically).⁵



Severe food insecurities

The World Food Programme (WFP) – the United Nations' frontline agency in the fight against global hunger – reported a decrease in the total number of food aid beneficiaries from 87.8 million in 2006 to 86.1 million in 2007.⁶ The number of people receiving emergency food assistance in conflict situations, however, rose from 7.7 million in 2006 to 8.1 million in 2007. In addition, the Food and Agriculture Organization (FAO) estimates that between 2003–2005 and again in 2007, high food prices contributed to an increase of 75 million in the number of undernourished people worldwide, bringing the total number to 923 million.⁷

Population movements

The number of refugees for whom the United Nations High Commission for Refugees (UNHCR) is responsible was estimated at 11.4 million at the end of 2007.⁸ The previous year, that figure was 9.9 million. However, in view of changes introduced in the methodology and scope for estimating refugee populations in a number of countries, the 2007 figure is not fully comparable with those of previous years.

By the end of 2007, developing countries were hosting 9.3 million refugees, or 82% of the global refugee population. At the end of 2007, there were 31 protracted refugee situations⁹ in 25 developing countries affecting 6.2 million refugees.

In 2007, more than 26 million people were estimated to have been displaced within their countries by armed conflicts and violence – the highest global total since the early 1990s.¹⁰

A methodological challenge

To analyse the magnitude of a humanitarian event and its trend over a given period, it is essential to know the size of the population living in the area affected by the event and the demographic evolution over the same period. The definitions adopted to categorize the events, the inclusive criteria, the reporting mechanisms and the methodologies used to process and analyse the data must remain comparable over time.

Unfortunately, in many humanitarian crises, baseline data are poor if not absent. Data collection may be problematic for security and/or logistic issues, and a variety of actors may collect and analyse data using diverse, incompatible and non-comparable methodologies.

Is the meaning of being affected by an armed conflict today the same as it was in 1945? Were natural disasters during the 1970s reported in the same manner as today? Is it useful to present data with crude numbers? Should we use proportional measures only? How large should the retrospective period be to allow proper identification of trends in natural disasters? These are just some examples of the dilemmas facing humanitarian analysts.

Humanitarian crises are increasingly becoming political events: they may be the direct consequence of political crises or they may be used to advance political agendas. Political considerations can, therefore, be an important factor to take into consideration when gathering information and analysing data.

However, humanitarian action cannot allow itself to be paralysed by political and technical difficulties. Field actions and global strategies must be based on holistic approaches including the technical capacity for qualitative and quantitative analysis and the political capacity to understand the social dynamics and underlying determinants of vulnerability.

Available data do not provide definitive evidence of an increase in the intensity or frequency of events that cause humanitarian crises. The reasons for reported increases in social and economic losses are probably related to a global rise in the vulnerability of populations due to poverty and to social, demographic and economic pressures, all of which provide fertile ground for humanitarian crises. Massive movements of refugees and increasing global urbanization together force large numbers of people to live in precarious settlements, often on unsafe land and in makeshift shelters with poor water and sanitation systems and little access to basic health services. Moreover, traditional relationships and values often disappear, disrupting community ties and breaking the bonds of partnership and mutual support that are the basis for effective community risk management. The resulting environmental degradation and unequal access to essential public health services are just some of the factors that can transform a natural hazard, an extreme weather condition or rapid social changes into a humanitarian crisis.¹¹

2008: continuing challenges

For each major emergency that is reported by the media and recorded in international databases, there are dozens of smaller emergencies that strike local communities, affecting the development and health of their populations. The following section describes WHO's engagement in some of those emergencies, both as leader of the Country Health Cluster and as a technical agency in its own right.

Zimbabwe



January

The results of **Kenya's** general election of December 2007 were greeted by nationwide protests that soon escalated into unprecedented violence. At least 1000 people were killed and another 300 000 dispersed in more than 200 camps in Nairobi, the Rift Valley, Nyanza, Western and Central provinces. Local services in resettlement areas were overwhelmed by the sudden influx of displaced people, many of whom were suffering from severe physical and psychosocial trauma. Critical shortages of staff and medicines were reported by mid-January. Urgent health needs in resettlement areas included emergency care for the wounded, basic health care (including reproductive health and chronic diseases), disease surveillance, and water quality control. Cases of respiratory infections, diarrhoea and malaria were reported in the camps; many people were unable to access health services due to the prevailing insecurity, further compounding a desperate situation. WHO deployed staff to its country office in Nairobi and to the field and assigned polio surveillance officers to strengthen disease monitoring in the most affected areas. WHO and its health partners assessed needs, coordinated health activities and assigned staff to each of the crisis working groups set up by the Ministry of Health. The Organization also donated five Interagency Emergency Health Kits¹² and four Trauma Kits A & B.¹³

Floods in **Malawi, Mozambique, Zambia** and **Zimbabwe** affected around 81 000 people, of whom 57 000 were displaced in Mozambique alone. The floods cut off access to health facilities and contaminated the water supply in many areas, increasing the risk of communicable disease outbreaks. In Mozambique, the situation was compounded by an ongoing cholera outbreak, with more than 1300 cases reported since October 2007. WHO offices in all four countries, backed up by WHO's emergency inter-country team in Harare, helped the Ministry of Health assess the impact of the floods on the environment, determine health needs and develop outbreak preparedness and response plans. WHO worked with national health authorities to deploy staff to the affected areas, strengthen field coordination, improve disease and nutritional surveillance and set up water quality control mechanisms. WHO also donated medicines and medical equipment to each country.



Kenya

In **Afghanistan**, cold weather and heavy snowfall killed almost 500 people and resulted in many cases of pneumonia and other acute respiratory infections. WHO donated medicines and medical supplies to the provincial health department of Herat and pre-positioned Emergency Health Kits in Ghor, Badghis and Farah. In cooperation with UNICEF, WHO also conducted rapid nutritional assessments and actively coordinated the Country Health Cluster.

February

By early February, violent clashes between rebels and government troops in **Chad's** capital, N'Djamena, had left hundreds of people dead or injured and sent thousands more fleeing. At least 30 000 people took refuge in Kousseri, in neighbouring

Cameroon, putting local services under great strain. WHO deployed staff to Kousseri, donated two Interagency Emergency Health Kits and supported a mass measles and polio vaccination campaign for children in refugee and host communities. The Organization trained health workers on case management of epidemic diseases, strengthened disease surveillance and health coordination and launched a health and hygiene campaign targeting the local population. WHO also donated three Trauma Kits to Chad.

On 3 February, a 6.1-magnitude earthquake struck the eastern part of the **Democratic Republic of the Congo** (DRC) and neighbouring **Rwanda**, killing 44 people and injuring another 860. In DRC, WHO helped the South Kivu provincial health authorities conduct rapid damage and needs assessments, and donated medicines and surgical supplies to the Bukavu and Panzi hospitals. In Rwanda, WHO deployed an epidemiologist, a sanitation engineer and a communications expert to support health authorities. WHO donated emergency medicines to the Ministry of Health and helped assess hospital capacity in Kigali.

In the **occupied Palestinian territory**, weeks of restrictions on the movement of people and goods reached a new peak in February. All health services except emergency and intensive care were brought to a standstill in several of the Gaza Strip's 11 Ministry of Health hospitals. WHO monitored access to health facilities and worked with partners to ensure hospitals and health centres were supplied with fuel and essential medicines. WHO also monitored mental health services, supported nutritional surveillance, coordinated health activities and continued to advocate for the Palestinian people's right to health care.

Plunging temperatures and a crippling shortage of energy left many people in **Tajikistan** without heating or electricity in the midst of the harshest winter in decades. Primary health care services were paralysed by power and water cuts and shortages of medical supplies, and critical health services such as intensive and surgical care were severely compromised. WHO donated four generators to key regional medical facilities in order to keep basic services running. The Organization helped the Ministry of Health assess hospitals' coping strategies and shortages and develop contingency plans for the following winter. WHO also donated three Interagency Emergency Health Kits and two Interagency Diarrhoeal Disease Kits.¹⁴

By February, more than two months of flooding had affected almost 56 000 families throughout **Bolivia**. The stagnant flood waters posed a serious health risk, with reported cases of dengue, yellow fever, hemorrhagic dengue, hanta virus, malaria, conjunctivitis, diarrhoeal diseases, leptospirosis and respiratory diseases. WHO's Regional Office for the Americas deployed a disaster specialist, logistician and mental health expert to help with the overall response. The team supported coordination, epidemiological surveillance, vector control, supply management and resource mobilization, and trained national staff in emergency management.



March

Up to 332 000 people in **Madagascar** were affected by Cyclone Ivan, with almost 100 people reported dead and over 190 000 made homeless. Health infrastructures in Antananarivo were damaged and medical supplies were destroyed. Overcrowding and poor sanitation in temporary shelters increased the risk of waterborne diseases such as diarrhoea and cholera in a population already suffering from food insecurity and a poor general health status. Outside the capital, damaged roads and bridges hampered access to other parts of the country. WHO deployed an expert from its emergency inter-country team in Harare to help the Ministry of Health assess needs, conduct surveillance activities and plan and coordinate the emergency response. WHO and Health Cluster partners coordinated activities to re-establish access to health care, distribute essential drugs, reinforce epidemiological surveillance and provide primary health care through mobile services.

Floods spread across 13 provinces in **Ecuador**, affecting at least 315 000 people, of whom 21 500 sought refuge in temporary shelters. Several health centres and hospitals were damaged and water and power supplies were disrupted. WHO's Regional Office for the Americas helped the Ministry of Health assess damages, set up epidemiological surveillance and outbreak control systems, and establish basic sanitation and vector control measures.

The humanitarian situation in **Iraq** remained critical, with largely inadequate health care, acute shortages of vital medicines, unreliable water and sanitation services and faltering electricity supplies. Renewed fighting in Basra left hospitals struggling to cope with the influx of wounded. WHO donated medicines and medical supplies to hospitals in Sadr City and Basra and began collecting statistics to set up an injury surveillance system and strengthen emergency medical services. WHO also advocated for humanitarian corridors during emergencies, the safe movement of ambulances, access to care, and the protection of health facilities, stores and medical supplies.

Fighting in the **Comoros** threatened to further disrupt fragile health, water and sanitation systems that were already faced with an ongoing cholera outbreak (1564 cases between January 2006 and March 2008). WHO's Regional Office for Africa deployed an emergency expert to participate in an inter-agency needs assessment. WHO supported health assessments, coordinated Health Cluster activities, strengthened epidemiological surveillance and donated 21 Interagency Emergency HealthKits and one Interagency Diarrhoeal Disease Kit.



April

In **Namibia**, floods in the northern Oshana and Ohangwena regions affected more than 62 000 people and displaced around 4000. Health clinics were cut off and damaged roads prevented outreach services and aid from reaching affected areas. Displaced persons in camps lacked access to safe water and sanitation, and mosquitoes breeding in stagnant water greatly increased the risk of infectious diseases. The situation was further complicated by a cholera outbreak in Ohangwena's Engela district, where 123 cases had been reported by 16 March. WHO helped the Ministry of Health formulate a cholera response strategy and donated an Interagency Diarrhoeal Disease Kit. The Organization deployed an epidemiologist and a laboratory expert to help authorities strengthen epidemiological and nutritional surveillance and launch health education campaigns on malaria, diarrhoea, HIV/AIDS, malnutrition and hygiene and sanitation.

WHO also advised health authorities on stockpiling medicines and establishing mobile health services in hard-to-reach areas.

An upsurge in armed violence in **Gaza** resulted in the deaths of around 200 people. Hospitals were overwhelmed by the numbers of wounded, while several health clinics were hit and medical assets destroyed. WHO donated 25 Surgical Kits to the Gaza Strip's 11 hospitals.

In **Sudan**, armed attacks on villages in West Darfur killed scores of people and displaced thousands more. Almost all health centres suffered serious damages, with medicines, equipment and furniture partially or totally looted. Most health care providers fled, leaving people without health care. WHO and its partners worked with the state health authorities to conduct field assessments and restore access to primary health care for local communities.

In **Angola**, heavy rains and floods in Cunene, Kuan-do Kubango and Benguela provinces exacerbated the ongoing cholera outbreak. As of 23 March, 3949 cases and 130 deaths had been reported nationally, with Cunene province accounting for 36% of all cases. The case fatality rate ranged from 5% in Cunene to 17% in Bengo and 26% in Huambo. WHO participated in the National Cholera Task Force and its Water, Sanitation and Social Mobilization sub-group, and helped the Ministry of Health strengthen national surveillance and case management in cholera treatment centres. WHO donated three Interagency Diarrhoeal Disease Kits and one Interagency Emergency Health Kit.



Myanmar

By April, the stalemate following the presidential elections in **Zimbabwe** had reached a critical point, with numerous reports of increasing violence and people fleeing their homes. Cholera and diarrhoea outbreaks began appearing, mainly in urban areas, exacerbated by acute water shortages and poor hygiene and sanitation. WHO, UNICEF and partners pre-positioned intravenous fluids, sachets of oral rehydration salts and emergency tents. WHO donated one Interagency Emergency Health Kit, three Trauma Kits A & B and three Interagency Diarrhoeal Disease Kits.

May

On 2 and 3 May, Cyclone Nargis swept through **Myanmar's** Irrawaddy delta region and the former capital Yangon, causing unprecedented devastation. By 18 May, more than 78 000 people had been reported dead and at least 56 000 missing, while up to 2.4 million people were severely affected by the cyclone's passage. Health facilities were damaged and many health personnel were missing or displaced. Overcrowding and poor sanitation in temporary shelters increased the risk of communicable disease outbreaks. WHO was able to deploy a total of 140 staff through its Polio network for the emergency response. WHO worked with the Ministry of Health to assess the health situation, identify priority needs, coordinate Health Cluster operations and intensify surveillance to prevent outbreaks of communicable diseases such as dysentery, cholera, malaria and dengue. WHO also provided technical guidance on various topics¹⁵ to the Ministry of Health and Health Cluster partners, and donated 40 Interagency Emergency Health Kits, six Interagency Diarrhoeal Disease Kits and 33 000 insecticide-treated bed nets. Together with the International Federation of Red Cross and Red Crescent Societies and the Myanmar Red Cross, WHO conducted refresher training for Red Cross volunteers and briefed incoming foreign medical teams.

On 12 May, a 7.9-magnitude earthquake rocked **China's** Wenchuan County, north-west of the Sichuan provincial capital Chengdu. As of 23 May, the official death toll was 55 740 people, with over 290 000 injured and almost 25 000 missing. The immediate

priorities were to treat the injured, set up communicable disease surveillance and control, ensure supplies of safe water and food, provide counselling to survivors and restore the health care system. WHO advised the Ministry of Health on trauma assessment, treatment of injuries, psychosocial support and rehabilitation of the health care system. WHO provided guidelines on psychosocial counselling and donated emergency medicines including two Trauma Kits A & B, 50 Surgical Kits and four water purification systems.

The destruction and looting of health facilities in war-torn **Central African Republic**, where maternal mortality is one of the highest in Africa,¹⁶ left women of reproductive age particularly vulnerable. WHO, UNFPA and UNICEF worked with national health authorities and Health Cluster partners to expand and strengthen emergency obstetric and neonatal services and increase community involvement in safe pregnancy and deliveries. Together



with the Ministry of Health and nongovernmental organizations, WHO donated basic reproductive health equipment and medicines, trained and supervised health teams and supported emergency obstetric care.

June

By early June, violence against foreign workers in **South Africa** had killed a reported 42 people and wounded another 550 in townships and informal settlements in the provinces of Western Cape, KwaZulu Natal, Mpumalanga, North Western and Free State. According to the National Disaster Management Centre, more than 39 000 people were displaced as a result of the violence. The main challenges were to reach out to and assist the displaced population scattered in 109 shelters and maintain disease surveillance and early warning systems. WHO helped the Ministry of Health and partners assess needs, strengthen disease surveillance, raise resources and coordinate the health response.

WHO sent medical supplies to Abyei in **Sudan** to provide emergency relief for people displaced by violence the previous month. Following a peace accord signed on 8 June, a high-level United Nations mission, including WHO representatives, visited the town to start planning reconstruction efforts and the return of the displaced.

By June, the number of people in need of urgent food aid in **Ethiopia** had risen from 2.2 million to 4.6 million due to the continuing drought. The failure of seasonal crops, loss of livestock and spiralling cost of food in local markets left many with no other option but to rely on assistance from the humanitarian community. Between January and May, 521 cases of acute watery diarrhoea and 7145 cases of measles had been reported in Amhara, Oromiya, Southern Nations, Nationalities and Peoples and Somali regions. WHO deployed experts to help the regional health bureaus respond to health and nutrition needs and implement measles vaccination campaigns. WHO also disseminated health education and communication materials and donated community treatment centre kits, each containing water treatment chemicals and medicines.

Somalia was faced with a severe drought and acute water shortages, particularly in the central-south area of the country. The crisis was exacerbated by continuing clan warfare, growing population displacements, hyperinflation and a barely-functioning health system. The scarcity of water, widespread malnutrition and unhygienic living conditions raised fears of outbreaks of communicable diseases such as cholera, meningitis and measles. WHO international staff in Lower Shabelle and Wajid supported surveillance, outbreak response and Health Cluster coordination, while WHO-trained national staff ensured the continuation of activities in the field. WHO pre-positioned drugs and medical supplies, including trauma and cholera kits, in all 10 regions of south-central Somalia, under the care of partner nongovernmental organizations. WHO's early warning system continued



to function in spite of the growing conflict, and an epidemiological bulletin was regularly produced.

In eastern **Chad**, endless armed clashes and security incidents forced several nongovernmental organizations to withdraw from the area, jeopardizing disease surveillance systems and disrupting health care services in Iriba and Adre district hospitals and elsewhere. WHO, as lead of the Health Cluster continued to support the work of remaining nongovernmental organizations and donated essential drugs and supplies to health partners. WHO and its Health Cluster partners supported the implementation of outbreak preparedness and response plans for communicable diseases including meningitis and hepatitis E, and helped the Ouaddai regional health authorities assess the capacities and needs of all eight laboratories in the region.

In Karamoja, north-eastern **Uganda**, communities from drought-affected areas were moved to resettlement sites with water and pasture but no basic health services. WHO worked with Health Cluster partners to set up a disease and nutritional surveillance system and strengthen community-based health initiatives, including the creation of village health teams to deliver basic health care and community health education.

July

In **West Africa**, seasonal floods in Benin, Burkina Faso, Ghana, Liberia, Mali, Mauritania, Niger, Nigeria, Sierra Leone and Togo destroyed agricultural lands and devastated food crops, further exacerbating the region's food security crisis. Several of the countries affected¹⁷ were among the 21 worldwide identified by WHO as being most at risk from the food crisis. Around 200 000 displaced people sought refuge in temporary shelters, raising concerns about potential outbreaks of malaria, diarrhoeal diseases and respiratory infections, especially among malnourished children. WHO donated six Interagency Emergency Health Kits it had pre-positioned in the region in anticipation of the seasonal floods. The Organization also worked with Ministries of Health to assess needs, strengthen case management of communicable diseases, train health workers, reinforce outbreak surveillance and investigation, chlorinate water sources and launch health education campaigns.

In **Pakistan**, monsoon rains flooded Balochistan, Punjab and the North-West Frontier Province, killing at least 20 people, destroying communication and power systems and damaging the water supply. Hundreds of homes were washed away and up to 700 000 people were affected. Respiratory tract infections, skin diseases and acute diarrhoea were the main diseases affecting the displaced population. WHO monitored the situation in all areas and helped the health authorities assess needs and set up an early reporting and investigation system for communicable disease outbreaks. WHO had already pre-positioned Interagency Diarrhoeal Disease Kits in all three provinces as part of the monsoon contingency plan.



In the **Democratic People's Republic of Korea**, WHO continued supporting maternal and child health services in the previously inaccessible provinces of Chagang, North Hamgyong and Ryanggang. Although the overall health status of women and children showed some improvement, high rates of malnutrition remained a major concern. WHO helped the Ministry of Health implement health and nutrition interventions for around 2.3 million people, including 40 000 pregnant women, 35 000 newborns and more than 130 000 children under five. WHO and the Ministry worked to ensure that health care facilities and maternity and paediatric wards were supplied with essential medicines and that local health systems were better able to cope with cases of acute malnutrition.

August

Following seasonal floods that affected several countries in eastern Europe, WHO deployed an assessment team to support health authorities in **Ukraine**, and advised health authorities in **Moldova** on priority interventions.



More than 150 000 people were displaced by the conflict in **Georgia**, with nearly 100 000 temporarily settled in collective centres in Tbilisi and Gori. Access to areas in the conflict zone in and around South Ossetia remained severely restricted due to military operations and general insecurity. Priority needs for the displaced included the provision of health care, safe drinking water and proper shelter and sanitation. WHO monitored the situation through its country office in Georgia and its North Caucasus field office in Vladikavkaz (Russian Federation). As the lead agency of the Health Cluster, WHO helped assess and monitor critical health needs in IDP settlements, supported disease surveillance and control and helped establish primary health care and public health services for displaced and vulnerable populations. Other interventions focused on mental health and psychosocial support, in close collaboration with local nongovernmental organizations. WHO coordinated the health sector component of the subsequent joint needs assessment led by the Georgian Government, the World Bank, the European Union and various United Nations agencies.

WHO conducted primary health care workshops in the **North Caucasus** as part of efforts to rehabilitate health care services in Chechnya and Ingushetia following two successive conflicts.

In north **Viet Nam**, Tropical Storm Kammuri triggered flash floods and landslides that killed at least 97 people, damaged thousands of houses and destroyed roads, dykes and bridges. Two provincial hospitals and 17 health centres were damaged and several health facilities were cut off. WHO donated 100 Emergency Health Kits to Lao Cai and Yen Bai provincial health authorities and helped coordinate assessment, monitoring and technical assistance.

Heavy rains in the Zinder region of **Niger** affected at least 24 000 people, of whom many were displaced and in urgent need of health care, food and other basic items. WHO donated two Interagency Emergency Health Kits, one Interagency Diarrhoeal Disease Kit and malaria medicines.

On 18 August, the Koshi River broke its embankment, flooding villages and submerging large areas of land in **Nepal** and neighbouring **India**. More than 2.6 million people were affected by the river's breach, and around 54 000 were forced to flee their homes. The risk of water- and vector-borne diseases was high due to massive population displacements, heat, overstretched hygiene and sanitation facilities and stagnant water. In Nepal, WHO sent medicines and equipment to the 27 shelters set up in flooded areas and pre-positioned additional medicines and supplies. WHO staff also participated in joint field missions to assess and respond to health needs. In India, WHO supplied 100 chloroscopes for water quality control as well as emergency medicines and equipment and health promotion materials. The Organization also helped health authorities and partners strengthen disease surveillance, conduct child immunization campaigns and provide safe drinking water.

September

A string of fierce tropical storms – Fay, Gustav, Hanna and Ike – struck **Haiti** in a period of less than one month, killing at least 420 people and affecting more than 800 000, of whom almost 80% were estimated to be women and children. Floodwaters and mud-

slides swept away roads and bridges, inundated hospitals and damaged or destroyed thousands of homes. Health care services were severely disrupted, with reported shortages of medicines and medical supplies including insulin and anaesthetics. Gonaives, the capital of the Artibonite department, was badly hit and its health system suffered substantial damages. The storms also washed away meagre food supplies, increasing nutritional risks in the impoverished population. Staff from WHO's Regional Office for the Americas supported the delivery of medical supplies, assessed needs, advised on the management of dead bodies and helped strengthen epidemiological surveillance.

In **Cuba**, 2.6 million people – just under a quarter of the population – were evacuated ahead of Hurricane Ike. Four other storms and hurricanes made landfall in Cuba in 2008, making it one of the worst hurricane seasons on record. Medical facilities in the west, particularly Pinar del Río and Isla de la Juventud, were extensively damaged, jeopardizing health care services and hampering disease surveillance and control activities. With assistance from donors, WHO's Regional



Office for the Americas purchased materials and equipment to restore hospitals and primary health care facilities in the affected areas.

In the **Philippines**, communities in the southern island of Mindanao were severely affected by the armed conflict between rebels and government forces. More than 510 000 people were displaced at the height of the conflict, with almost 65 500 still living in shelters. Overcrowding and poor sanitation in temporary shelters left displaced people particularly vulnerable to diarrhoea and respiratory infections. WHO donated funds to support emergency health needs and provided technical support and guidance to the regional Health Clusters in the affected areas. The Country Health Cluster, led by WHO, worked with local government officials and nongovernmental organizations to strengthen coordination and information management.

October

In **Kyrgyzstan**, a 6.6 magnitude earthquake struck the villages of Nura and Sary-Tash bordering Tajikistan and China. Two Interagency Emergency Health Kits donated earlier by WHO and pre-positioned in Osh Hospital's warehouse ensured the availability of essential medicines.

Torrential rains caused heavy flooding in the eastern Hadramout and Al-Mahra governorates of **Yemen**. As of 29 October, 180 people were reported dead and 10 000 displaced. Waterborne diseases and malaria were the main health concerns. Access to and restoration of health services were critical to prevent avoidable deaths and illnesses from acute respiratory infections, measles and pregnancy complications. WHO helped the Ministry of Health coordinate the emergency health response and strengthen surveillance and vector control. WHO donated an Interagency Emergency Health Kit and arranged for the delivery of additional medicines and supplies for up to 20 000 people, including drugs to treat malaria and diarrhoeal diseases.

On 29 October, a 6.4 magnitude earthquake hit **Pakistan's** Balochistan province in a remote, mountainous region north-east of Quetta. The Government reported 150 dead and 300 injured in Ziarat district, which was the worst hit, and another 500 households affected in Pishin district. Lack of access to health services, exposure to freezing temperatures at night and low immunization coverage, especially for measles and tetanus, were the main health concerns. WHO and its United Nations partners conducted field assessments to obtain a clearer picture of health needs. WHO donated medicines and trauma surgery supplies for the emergency response.



November

In the **Democratic Republic of the Congo**, an estimated 250 000 people fled renewed fighting in North Kivu. The violence exacerbated an already desperate situation in the troubled region, where more than one million people, many of whom had fled the violence several times, were living without clean water, food or access to health care. The near-total absence of clean water and sanitation raised concerns over potential cholera outbreaks, and cases of measles were reported in the areas affected by the conflict. WHO's team in Goma worked with the Ministry of Health and health partners to train health staff on case management of cholera, vaccinate children under five against measles and polio and distribute medical supplies. WHO pre-positioned emergency supplies in neighbouring Uganda and Rwanda and strengthened its presence in the Kivus in order to improve disease surveillance, early warning and outbreak response. WHO donated 61 tons of medicines to agencies operating in Goma and provided health facilities with 25 000 litres of Ringer lactate and eight sets of water purification equipment.

December

As of 31 December, 31 656 cases of cholera had been reported in **Zimbabwe**, with a case fatality rate of more than five times the acceptable threshold.¹⁸ The outbreak – the most visible indication of the country's tottering health system and overall economic collapse – was exacerbated by the breakdown of infrastructures, lack of safe drinking water, poor sanitation and striking health staff. As lead agency of the Health Cluster, WHO worked with the Ministry of Health and Child Welfare, health partners and nongovernmental organizations to address the outbreak. The Health Cluster established a cholera command and control centre in WHO's country office in Harare, with equipment donated by WHO, and set up an early alert and response system focusing primarily on urban centres across the country. Health Cluster partners developed a comprehensive cholera response plan addressing gaps in detection, assessment, response, case management, surveillance and public information. WHO dispatched an outbreak investigation and response team of epidemiologists, water and sanitation experts, logisticians and social mobilization and media specialists. The Organization also donated five Interagency Emergency Health Kits, eight Interagency Diarrhoeal Disease Kits and 11 000 litres of Ringer lactate.

In **Kyrgyzstan**, WHO participated in a joint United Nations contingency planning exercise for the forthcoming winter. Together with health partners, WHO assessed potential scenarios and health needs and developed a preparedness strategy for the health system. The strategy is designed to prevent potential health problems arising from another spell of abnormally cold weather and energy supply shortages. It also identifies ways to raise resources for priority health interventions.

Crisis issues

Humanitarian health action is complex and many-faceted. The following section focuses on some of the issues that were particularly relevant to WHO's work in humanitarian crises during 2008.



Improving mortality and nutrition data collection and analysis in crises

The Health and Nutrition Tracking Service (HNTS), hosted by WHO, is an interagency initiative that aims to provide impartial, credible and timely information on mortality and malnutrition rates in populations affected by crises, using standardized data collection and analysis methods wherever possible. The information gathered will help improve humanitarian operations by: (1) rapidly detecting excess mortality and malnutrition in crises using key indicators; (2) promoting mutual accountability between the humanitarian community and beneficiaries; and (3) ensuring evidence-based information on health and nutrition needs in crises is available to high-level decision-makers.

The HNTS has two main functions. It offers operational support to humanitarian staff in the field by peer-reviewing assessment guidelines and other documents, participating in assessment missions, advising on the design of surveys, and providing technical advice to various agencies. Its normative functions include developing standards for data collection and measurement through its Expert Reference Group, collecting, analysing and disseminating data, and providing independent technical advice on various issues related to method development and validation studies.

In 2008, the HNTS provided support, advice and assistance to humanitarian operations in the Central African Republic, Chad, Kenya, Myanmar, Pakistan, Sudan and Uganda. It also supported the development of various tools (including a rapid assessment tool) and information systems, collaborated with the SPHERE project and the Somalia Food Security Analysis Unit, and peer-reviewed documents prepared by the Integrated Food Security Phase Classification.

Following several field visits to Uganda and the Democratic Republic of the Congo (DRC), the HNTS team developed a software application (the Health Information and Nutrition Tracking System) and related guidelines for tracking health events and nutrition status in health facilities. The system is currently being used by national health authorities in eastern DRC.

In Myanmar, the HNTS collected and analysed data on health needs and responses following Cyclone Nargis, and participated in the Post-Nargis Joint Assessment mission led by the Association of Southeast Asian Nations, the Government of Myanmar and the United Nations, with technical support from the World Bank and the Asian Development Bank.¹⁹

The HNTS also commissioned two technical studies that are awaiting review by the HNTS Expert Reference Group in 2009. The first study – *Priority indicators in complex emergencies: summary* – reviews work conducted to date as part of the effort to develop a priority list of health indicators to be used in emergency settings. The report has five components: (1) a review of policies in selected organizations; (2) interviews with 11 nongovernmental organizations in four countries regarding their data collection methods; (3) a brief review of the evidence base for the SPHERE Indicators that form the basis for many nongovernmental organization indicator collection policies; (4) a review of past publications on emergency health indicators;



and (5) a set of recommendations. A second document – *Mortality estimates in crisis-affected populations: inference from multiple sources* – considers the problem of combining different sources of information on mortality into one single estimate of the death toll attributable to crises. The document explores quality scoring of sources and metadata collection and re-analysis of important datasets if needed. It proposes a survey ranking system and suggests possible uses of surveillance and body count data. Outstanding issues, limitations and possible next steps are also discussed.

The HNTS convened two meetings of its Steering Committee in 2008 (one in January and a second in July).

Using the cluster approach at country level to improve humanitarian health action

Throughout 2008, WHO worked to prepare all levels of the Organization – particularly country offices – for the challenge of leading the work of the Health Cluster.

As part of its efforts to build sector-wide capacity, the Global Health Cluster (GHC), led by WHO, conducted three training courses for Health Cluster Coordinators. All participants were assessed, and those deemed suitable for deployment were placed on WHO's emergency roster. The GHC visited four countries – Afghanistan, the Central African Republic, Chad and Côte d'Ivoire – to review constraints to cluster implementation and learn lessons. It subsequently developed recommendations for strengthening countries' capacity to deliver humanitarian assistance through the cluster approach. Other activities included a sub-regional workshop in the Horn of Africa to address the issues specific to the sub-region, including the food price crisis. The GHC also continued its normative work developing and supporting the use of guidance and tools for use at country level.

Internally, WHO built awareness of the Health Cluster approach by including it in its emergency handbook, pre-deployment training courses and briefing sessions for WHO Representatives and regional office staff. Similarly, WHO's partner agencies integrated the cluster approach in their own training courses, field missions and manuals.

By the end of 2008, the cluster approach had been used in 19 of the 26 countries affected by protracted crises and in another 13 countries faced with sudden-onset emergencies. In all instances, WHO worked with national and international partners through the cluster approach to provide more effective health care and services. These efforts began to take root in 2008. Several country-level Health Clusters were able to coordinate health activities, pool their capacities and jointly assess and plan while tapping and building on local capacities and priorities.

Implementing the cluster approach has not been without challenges. There has been some resistance to adopting a new way of work that is being introduced in a top-down approach and that entails significantly increased responsibilities for the WHO Representative in each country. These demands include:



being responsible for the performance of the entire health sector; being provider of last resort when no other stakeholder is willing or able to fill agreed priority gaps; and being responsible for mobilizing donors and other stakeholders around sector-wide priorities. Moreover, the cluster approach requires a willingness to go beyond the limits of organizational hierarchies and be accountable to a Humanitarian Coordinator who more often than not is part of another United Nations agency. WHO will need to re-organize its resources and adapt its procedures if it is to meet these challenges.

Communicable disease control in humanitarian emergencies

WHO's Disease Control in Humanitarian Emergencies (DCE) unit, based in the Health Security and Environment (HSE) Cluster, provides technical and operational epidemiological services to all WHO offices and to national authorities, other United Nations agencies and nongovernmental and international organizations for the surveillance, monitoring and control of communicable diseases in humanitarian emergencies. Activities focus on field epidemiology, training and the publication of technical standards, guidelines and tools. DCE coordinates the Communicable Diseases Working Group on Emergencies (CD-WGE) comprising WHO experts in various areas including pneumonia, diarrhoeal diseases, malaria, measles, TB/HIV, immunization, water and sanitation, child health, surveillance/early warning and outbreak response, vector control, nutrition, food safety and injuries/wounds. In addition to providing expert advice, the CD-WGE helps set standards and prioritize interventions in acute and protracted humanitarian emergencies.

In 2008, DCE and the CD-WGE developed disease risk assessments following the post-election emergency in Kenya, Cyclone Nargis in Myanmar and the Sichuan earthquake in China. DCE deployed epidemiological teams to set up early warning

disease surveillance systems in the Democratic Republic of the Congo (following renewed conflict in Goma), Myanmar (after Cyclone Nargis) and Zimbabwe (in response to the cholera outbreak). DCE also conducted intensive five-day training courses on communicable diseases in emergencies. Two such courses targeting health advisers and coordinators in partner agencies were held in 2008, one in Geneva and one in London (with the London School of Hygiene and Tropical Medicine). DCE also provided technical support for WHO's public health pre-deployment training courses in Tunisia and Canada. Key publications in 2008 included: *Public health in crisis-affected populations: a practical guide for decision makers* (ODI Network Paper); *Manual for health care of children in emergencies* (WHO); and *Reducing excess mortality during a severe influenza pandemic: WHO guidelines for community-based prevention and treatment of common illnesses in low resource settings*.



Communicating health action in crises

Prompt and regular communication to partners, Member States and the media about the health situation and unmet health care needs in crises is one of WHO's basic responsibilities, for it provides essential support for the Organization's leadership, coordination and advocacy efforts.

In an unfolding emergency caused by conflict or natural disasters, rapidly gathering information and communicating the needs of the affected population is crucial for mobilizing resources and organizing an effective response.

In 2008, WHO expanded its communication capabilities in order to better meet the needs of partners and donors and better respond to requests from the public and the media for more information on health action in crises. The many sources of information made available include WHO and Health Cluster activity reports, morbidity and mortality bulletins, weekly highlights, press releases, updates on funding needs, photo stories, assessments and maps.

A new web page was created to promote WHO's response to the health challenges posed by the global food security crisis (http://www.who.int/food_crisis/en/index.html). WHO also issues a weekly update – the *Highlights* – on critical health-related activities in countries where there are ongoing humanitarian crises. Drawing on various WHO programmes, the *Highlights* cover the activities of field and country offices and describe the support provided by WHO regional offices and headquarters (<http://www.who.int/hac/donorinfo/highlights/en/index.html>).

WHO's headquarters office promotes active communication between staff in Geneva and field offices. Regular updates on programme activities in the field are used to help shape and direct the overall health response.

The main web site for obtaining information on WHO's emergency and humanitarian work can be found at <http://www.who.int/hac/en/>.

The latest news and updates on public health emergencies and disasters is also now available by RSS feed at <http://www.who.int/about/licensing/rss/en/>.

Staff competency: a critical element

Experience has shown that humanitarian health expertise is often not readily available in an emergency. WHO has developed a humanitarian training programme to help ensure the right person can be deployed to the right place at the right time, before, during and after crises. The Organization's training strategy aims to not only identify, select and train the right people but to deploy, retain and motivate them by providing appropriate training packages as part of a career development plan. The different packages on offer include induction briefings, training courses for emergency health focal points and WHO coordinators, and more advanced coaching for experienced health professionals who have the potential to become Health Cluster Coordinators.

WHO has established a training platform at its Mediterranean Centre for Health Risk Reduction (WMC) in Tunisia, where it organizes training courses, workshops and other events. In collaboration with its Regional Offices and various partners, WHO organized the following humanitarian training courses in 2008:

Public Health Pre-Deployment Course (PHPD)

Two PHPD courses were held in 2008 (the first in Hammamet, Tunisia and the second in Ontario, Canada). This 14-day residential training course aims to prepare public health professionals to: (1) work effectively, efficiently and safely in emergencies; (2) be able to coordinate the work of emergency health teams; and (3) function efficiently within the Health Cluster and with other clusters. A total of 48 people were trained in 2008.

Health Cluster Coordinators Course

As the lead agency of the Global Health Cluster, WHO is responsible for ensuring that Health Cluster Coordinators are properly selected and trained. WHO organized three training courses in 2008 to ensure that potential cluster coordinators were equipped with the technical, managerial and leaderships skills needed to perform effectively at country level. Two of the three courses were jointly organized as tri-cluster workshops with the Water, Sanitation & Hygiene and the Nutrition Clusters. A third course was for Health Cluster candidates only. A total of 41 staff from WHO and partner agencies were trained in 2008.

Analysing Disrupted Health Systems in Countries in Crisis

This 12-day residential training programme, organized in collaboration with Merlin and the International Rescue Committee, teaches participants how to analyse the health systems of countries affected by or recovering from protracted crises and how to develop tailored response and recovery strategies. It is aimed at humanitarian health professionals including WHO staff, health personnel working in government institutions, nongovernmental organizations, United Nations agencies and other humanitarian organizations. Thirty-one health professionals attended the course held in Tunis in November 2008.

WHO plans to offer the above courses in French in 2009.

WHO Mediterranean Centre for Health Risk Reduction

The WHO Mediterranean Centre for Health Risk Reduction (WMC) in Tunis is a global resource for social mobilization, training and operational research. The WMC's activities focus on:

■ Training programmes and other events

The WMC offers cost-effective event organization services to WHO and other United Nations agencies. In 2008, the WMC organized and hosted 14 meetings and events on behalf of different WHO departments and other United Nations agencies including UNAIDS and UNICEF.

■ Vulnerability and risk assessment & mapping

The Centre supports Member States' efforts to strengthen their capacity to assess and analyse health risks and incorporate the results in emergency preparedness and response plans. Through its Vulnerability and Risk Assessment and Mapping project (VRAM), the WMC provides baseline data and information that can be used by health authorities and partners in times of crises. In 2008, VRAM activities were launched in Ethiopia, Ghana, Mexico and Nigeria.

■ Operational research, health information and knowledge management

In coordination with its partners, the WMC supports the creation, analysis, use and dissemination of information on health risk reduction and emergency preparedness and response.

■ Health communication, social mobilization and community systems strengthening

WMC is building health communication and social mobilization capacity through the development of a network of experts and institutions that can assist governments in the design and delivery of social mobilization and behaviour change programmes.

WMC also hosts and facilitates regional and interregional initiatives including intergovernmental programmes for health security.

Getting operational

Emergency supplies

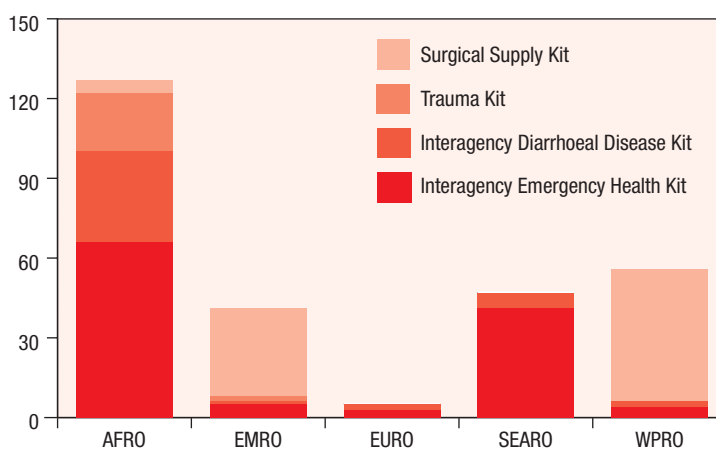
WHO's substantial global stockpiles of emergency health and medical kits have the advantage of both speed and predictability, with medical commodities packaged in standard kits that can be transported whole or broken down into smaller units. In 2008, WHO dispatched emergency medicines and medical supplies to 26 countries and territories²⁰ from stocks held either with vendors or in the regional humanitarian supply depots managed by the WFP. WHO dispatched enough medicines and medical supplies

to meet the basic health needs of almost 1.2 million people for three months, treat 31 500 cases of moderate to severe diarrhoea, and support over 11 000 surgical interventions.

Emergency support

Emergency staff from the relevant regional office were deployed in all major crises in 2008. From WHO headquarters, international experts were deployed to strengthen the capacity of country and field offices in the Democratic Republic of the Congo, Ethiopia, Georgia, Haiti, India, Kenya, Myanmar, Nepal, Niger, Rwanda, South Ossetia, Tajikistan, Thailand, Uganda and Zimbabwe. Headquarters staff moved to WHO's Strategic Health Operations Centre in order to better support emergency operations in China, the Democratic Republic of the Congo, Myanmar, Pakistan and Zimbabwe.

Emergency supplies sent to Regional Offices in 2008



Collaboration with WFP

WHO continued to extend its strategic partnership with WFP within the framework of the joint technical agreement for logistic cooperation. WHO and WFP are discussing ways of expanding joint operational platforms at regional and country levels and making better joint use of resources, for example by using WFP field staff during polio immunization campaigns, combining food distribution and polio vaccination rounds, and expanding WHO stocks in WFP supply hubs to include medicines for communicable disease outbreaks.

WHO humanitarian logistics meeting

WHO convened a humanitarian logistics meeting from 13 to 15 March 2008. The meeting brought together WHO's emergency regional advisers for discussions on streamlining logistics processes and clarifying the roles of the different WHO offices. Participants also explored ways of strengthening WHO's strategic partnership with WFP, making the most of funding opportunities offered by donors, and standardizing interactions between the Health and Logistics Clusters.

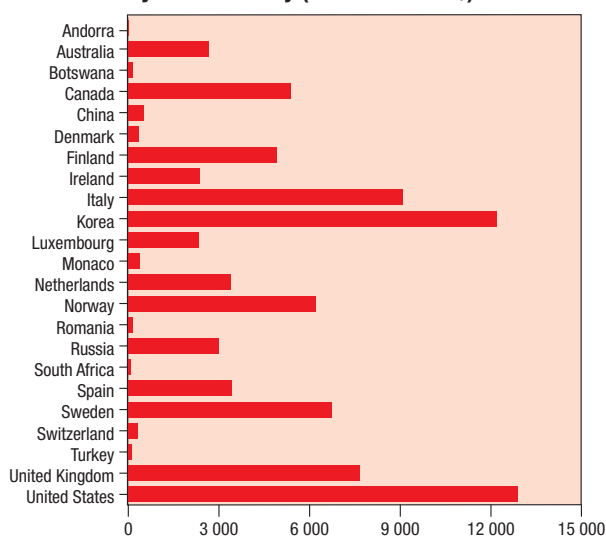
Funding for WHO's emergency work

WHO could not carry out its emergency work without the continuing generous contributions of its partners including individual donor governments and United Nations funding mechanisms such as the United Nations Central Emergency Response Fund (CERF). WHO relies almost entirely on these contributions to enable it to intervene promptly in disasters and complex emergencies and thus ensure better health outcomes for populations affected by crises.

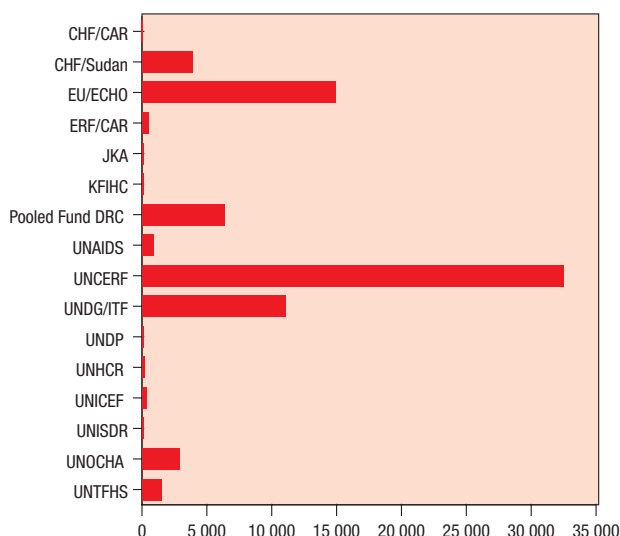
Contributions for WHO's emergency work rose to their highest-ever levels in 2008, with pledges and contributions of US\$ 197.5 million. The Eastern Mediterranean region received the largest proportion of funds, followed by the African region. WHO's efforts to broaden its donor base paid off in 2008, with contributions from several new donors. The CERF continued to be a major source of funding, with US\$ 32.5 million received in 2008 (of which almost two thirds was for rapid response operations and one third was for under-funded emergencies).

Implementation kept pace with donations. In 2008, the Organization spent a record US\$ 181 million – close to half its planned budget for the biennium – on its emergency work. This good news is tempered by the fact that WHO’s humanitarian work continues to be largely financed by voluntary contributions that are tightly earmarked for direct disaster relief.²² This restricts WHO’s ability to maintain the infrastructure – the logistics and supply systems, media and communications teams, information technology platforms, security arrangements and financial, administrative and project management back-up – that is essential to support its emergency operations in the field and ensure donors’ money is spent wisely and well. Given WHO’s increased responsibilities as the lead agency for the Health Cluster, the Organization is appealing to donors to contribute flexible and predictable funding to support these essential functions. Doing so will allow WHO to further improve its work in emergencies, strengthen its field presence and ensure the best possible use of donor funds. The *Five-Year Programme for 2009–2013 strengthening WHO’s institutional capacity for humanitarian health action* – sets out WHO’s overall strategy, objectives, activities and milestones in this regard.

Contributions received in 2008 by donor country (in thousand US\$)



Contributions received in 2008 by donor institution (in thousand US\$)



Legend:
 CHF/CAR: Common Humanitarian Fund Central African Republic
 CHF/Sudan: Common Humanitarian Fund Sudan
 EU/ECHO: European Commission - ECHO
 ERF/CAR: Emergency Response Fund Central African Republic
 JKA: Japan Kindergarten Association
 KFIHC: Korean Fund for International Health Care
 UNICEF: United Nations Central Emergency Response Fund
 UNDG/ITF: United Nations Development Group Iraq Trust Fund
 UNISDR: United Nations International Strategy for Disaster Risk Reduction
 UNTFHS: United Nations Trust Fund for Human Security

Primary health care in crises

WHO's World Health Report for 2008 called for a renewal of primary health care (PHC).

The following chapter calls for a renewed humanitarian health action agenda for PHC in a humanitarian context. It brings together several reference materials with a view to promoting strategic reflection on a renewed humanitarian health action agenda for PHC.

The term "humanitarian health action" is not limited to the activities of WHO's Health Action in Crises Cluster. It comprises all interventions conducted by health stakeholders in the fields of disaster risk reduction and health emergency preparedness, response and recovery.

The chapter briefly analyses the impact of humanitarian crises on the four strategic areas for reform proposed in the 2008 *World Health Report*: universal coverage, service delivery, leadership and public policy. It explores possible synergies between a holistic PHC approach and humanitarian action, and concludes by examining the broader issue of a rights-based approach in health action in emergency settings.

Voices from the field

“If we had been unable to provide primary health care services during the recent conflict, it would have been a disaster for health care throughout Gaza”, said Jihad Mattar, director of nursing for the Gaza Strip’s network of PHC centres. “Without PHC, where would the injured have gone for care after being discharged? Where would children go to be immunized? PHC in Gaza ensures more than 95% immunization coverage. This is what PHC means in emergencies. It means that public health care keeps being given to the whole population. **It is everyone’s right.**”

“Our health staff make home visits to elderly people, many of whom are bedridden, while missiles are landing around them. Many people are too sick, old or scared to go to hospitals, which are full anyway with wounded people and those suffering from stress. Some people suffer complications due to basic diseases, diabetes and respiratory problems. Some need at-home treatment for acute diseases and infections. Primary health care provides all this. It is not just a health service. **It ensures life.**”

Dr. Faibel Hedy, head of emergency services in southern Israel and staff member of Magen David Adom, Israel’s national emergency medical, disaster, ambulance and blood bank service.

“Our PHC services were absolutely needed, not just to treat people with chronic diseases such as heart problems, hypertension or neurological issues, but to provide some level of reassurance to the public that there was someone there willing and able to care for them”, said Alina Papanidi from Hellenicare, a Greek nongovernmental organization providing PHC services in Georgia during the Ossetia crisis. “People tell us that our mobile medical units were the only medical facilities providing health care, and just being there means a lot to them. All of them are under stress and even the presence of a doctor provides some **reassurance and psychological support.**”

“Primary health care facilities are cheaper and therefore everyone can use them, because people don’t have much money to spend on health care”, said nurse Esther Kurz who works in the Umoja, Buturande and Rutshuru areas of eastern DRC. “The fact that PHC services were available **right in the middle of the population** and that they were **free** was a great relief to people.”

a sudden increase in demand or because of weak systems and institutions (e.g. government and local services collapse due to staff shortages or lack of funds). The impact of humanitarian crises on health systems is often immense: a WHO survey showed that most countries (from 73% to 100%) reported facing a major emergency during the past five years.²⁴

During crises, health is on the front line. Health care delivery fragments and deteriorates, memory and knowledge erode, and power disperses. Unreliable and incomplete information hampers sound decision-making, while fast-evolving conditions increase uncertainty. Operating costs escalate. Security concerns add to stress and limit the humanitarian space to assist populations in need. The health response to crises is often complicated by competing demands over immediate humanitarian priorities and the need to keep routine health services functioning.

While investing in health service development from the beginning of the humanitarian response can provide long-term returns by alleviating suffering and facilitating the recovery process, the rapid rehabilitation of health systems following crises can be a key political tool in re-establishing the state's legitimacy, stabilizing public services and allowing civil society to address health inequalities.

Humanitarian health action as part of the PHC renewal: common principles and synergies

PHC and humanitarian health action have been perceived by some as two separate strategies to deliver health care.²⁵ However, they have much in common. Both aim to save lives, safeguard health and address environmental risks. The humanitarian principles of humanity, impartiality, independence and neutrality²⁶ are conceptually linked to the PHC principles of equity, participation, sustainability and intersectorality. Common principles and approaches for PHC and health action in humanitarian crises include the equitable distribution of resources on the basis of need, multisectoral involvement in managing health risks, and a community-based approach supported by national and sub-national systems.

Humanitarian crises exert an enormous toll on development and pose significant threats to prospects for achieving the MDGs,²⁷ the United Nations' framework for measuring human progress in areas such as health, poverty, education, equality and empowerment, environmental sustainability and partnership. Progress towards the MDGs has suffered serious setbacks in more than 50 countries currently facing crises.²⁸

While on the one hand humanitarian crises may severely disrupt development and the PHC renewal process, on the other hand they represent a unique opportunity to promote change. Humanitarian health action can promote sustainable development by increasing community resilience in the preparedness phase, protecting health, livelihoods and assets during the response phase and addressing the roots of the crisis in the recovery phase. PHC renewal and humanitarian health programmes can act in synergy. A holistic approach to health, incorporating humanitarian health action in the PHC renewal process, may help protect human health and assets and empower communities even when vital needs and rights are at critical risk.

The *World Health Report 2008* structures the PHC renewal process around four sets of reforms: universal coverage reforms; service delivery reforms; leadership reforms and public policy reforms. This structure reflects "the convergence between the evidence on what is needed for an effective response to the health challenges of today's world, the values of equities, solidarity and social justice that drive the PHC movement, and the growing expectations of the population in modernizing societies".

The following sections underline possible synergies between the four strategic areas of the PHC renewal process and humanitarian health action.



SERVICE DELIVERY

Synergy one: putting people first



Adopting a primary health care approach means putting people at the core of humanitarian health action by promoting community participation, restoring the ability to make choices and bringing essential life-lines closer to those in need.

Humanitarian crises, whatever their cause, are complex events that are subject to a variety of individual and social perspectives with diverse degrees of correlation. Just as each individual has his or her own way of adapting and coping with crises, each community has its own way of dealing with risks. Effective humanitarian health action must adopt a holistic approach based on comprehensive, integrated action and an in-depth understanding of both the context in which crises occur and the priority needs as perceived by the affected population. From the outset, immediate relief as well as recovery and development actions should be complemented by well-informed efforts to identify and restore key elements of social, economic and security systems. This is where a well-established primary care network with its in-depth knowledge of the local culture, including coping and adaptation strategies, can greatly enhance response capacity.

PHC renewal emphasizes the importance of systematically engaging and involving communities and stakeholders. While disaster risk reduction and health emergency preparedness programmes focus on community participation, humanitarian response demands immediate, life-saving interventions with apparently little space for participatory processes. Nonetheless, the need for immediate response is not incompatible with the concept of community participation. The community's involvement in assessing immediate needs and deciding response priorities is, in fact, increasingly part of humanitarian response strategies.

It is a myth that populations affected by crises are too shocked and helpless to take responsibility for their own survival. On the contrary, many people find new strength to address urgent and pre-existing health needs.²⁹ In the aftermath of an emergency, the local population is almost always the first to respond to immediate, life-saving needs. In Indonesia, 91% of rescue services in the first 48 hours following the Indian Ocean tsunami were provided by private individuals.³⁰

Evidence shows that locating the health system entry point closer to the population has measurable benefits in terms of relief from suffering, prevention of illness and death, and improved health equity. In humanitarian crises, however, the geographical distance between people and the health system entry point can dramatically increase. Health services may sustain considerable structural and infrastructural damage, with severe disruption of the health service network. Health workers may themselves be killed or injured, or obliged to leave crisis-affected areas for security reasons. Logistic and security constraints or displacement may also prevent some patients from using their regular source of care.

In addition, humanitarian crises alter both community health demands and the health system's ability to respond to such changes. For instance, survivors often report that their greatest stress arises from fears of attack and persecution, forced displacement, gender-based violence, separation from or abduction of family members, exploitation and ill treatment. Such problems produce immediate suffering and may interfere with the rebuilding of social networks and sense of community, both of which support psychosocial health. The need for psychosocial support services may dramatically increase.

Sexual and other forms of gender-based violence are increasingly reported during humanitarian crises. Their prevention and treatment need specific medical care which must be provided at the earliest stage of the humanitarian response. However, these types of medical services are usually not widely available in "normal" circumstances and are definitely not able to respond to increased demand.

Understanding the local capacity to deal with new demands for health care during crises, and improving the operational capacity to expand the health service network, are key elements of humanitarian health action.

Crises can be an opportunity to promote community participation and strengthen social cohesion and equity. The challenge for aid agencies is to use a truly participatory approach involving different segments of the community. Although aid agencies often claim they have no time to consult, they have a responsibility to talk with and learn from local people.³¹

Conclusion:

People are the first designers and implementers of risk adaptation strategies, and the first-line responders in crises. A community-centred approach to emergency preparedness and response is essential for building health resilience to disasters. Respect for the culture and health perceptions of members of the affected communities must be the focus of any health humanitarian action and/or service delivery reform.

Commercialization of health in crises

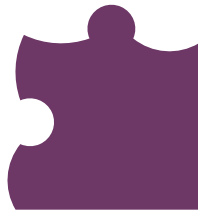
In most crisis-affected low- and middle-income countries, under-resourcing and fragmentation of health services have accelerated the development of commercialized health care, comprised of i) the unregulated fee-for-service sale of health care and ii) the unregulated private sector involvement in humanitarian aid.

Although the information available on cost recovery in emergency settings is extremely limited, there are arguments and evidence that justify concern over cost-recovery practices. Utilization rates indicate that, in already disrupted and inequitable health care environments, user fees compound inequities in access to treatment and contribute to the destitution of the most vulnerable.³² A basic humanitarian principle is that services and goods provided by aid agencies should be free of charge to the recipients. However, while this is generally respected in refugee interventions and in food aid, in contexts characterized by internally displaced populations or when the crisis affects a significant proportion of the resident population, the practice has often been to charge people user fees for health care services.³³ The pressing need for quality secondary health care became clear immediately after the beginning of the Darfur crisis in Sudan in early 2004. Hospitals in Darfur were desperately unprepared for the large influx of people requiring emergency care. In response to those pressing needs and to the limited access to secondary care due to the persistence of a cost recovery system, WHO initiated, with other partners, a hospital programme aimed at suspending the cost recovery system for internally displaced persons and conflict-affected populations and improving the quality of secondary care available in the area. This hospital programme was based on providing economic incentives for staff, covering running costs and providing medicines and medical supplies to the ten largest hospitals in Darfur. In addition, main hospital departments were rehabilitated and various training activities were conducted. Through a WHO initiative on the rational use of drugs, Sudan's National List of Essential Drugs was distributed to all hospitals in Darfur, a central medical supplier was nominated and a quality control system was put in place.

Another aspect of the commercialization of health care during crises is the increasing interest of the private sector in supporting humanitarian operations worldwide. While much of the private sector's involvement in humanitarian operations can be seen as fairly beneficial, there remain valid concerns that these activities, if not properly regulated, may undermine local capacity and public policies. It is also unclear whether private actors are motivated by, or even aware of, the guiding humanitarian principles of humanity, impartiality, independence and neutrality. To address those concerns, the World Economic Forum and the United Nations Office for the Coordination of Humanitarian Affairs have defined a set of principles to guide public-private collaboration for humanitarian action. These principles are meant to serve as a guide for the private sector and the humanitarian community, with an emphasis on communicating key humanitarian principles as well as integrating elements of lessons learnt from previous private sector engagement.³⁴

PUBLIC POLICIES

Synergy two: adopting public policies for health in crises



Humanitarian crises are moments when the public policies that constitute the cement of contemporary society break down.

Many factors conspire against effective policy making during crises. The state authority comes under pressure. Long-term initiatives are discouraged. The information to underpin decision-making is lacking. Stakeholders increase in number and are frequently replaced. Policy debates become politically influenced.

It is difficult to enforce transparency and accountability.³⁵ Capacity to monitor funds and resources and coordinate international aid is frequently weak at the very moment the need to optimize available resources becomes crucial. Public policies may be fragmented by (1) a multiplication of programmes and projects; (2) the drive for available external resources and parallel chains of command; (3) limited sustainability.

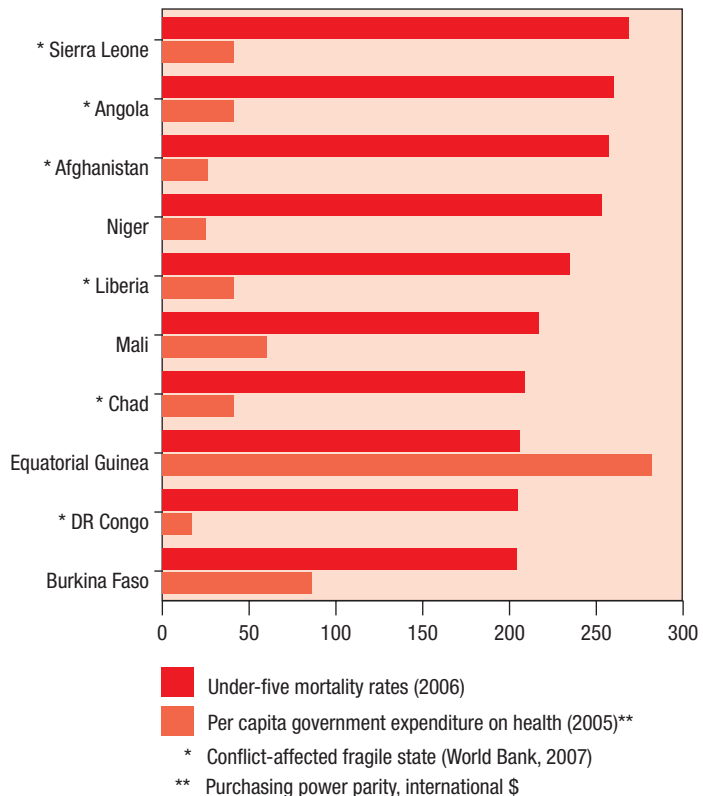
During humanitarian crises, there are too few political processes and opportunities that can be used to exert pressure on governments to meet basic social expectations. As a result, countries in crisis invest less in health, with predictably poor health consequences.

Weak public policies and withdrawal of the state from its public health responsibilities place the health of the community at risk and contribute to a state of perpetual crisis in the health system, which lurches from one internal emergency to another. It becomes increasingly difficult to promote public policies *during* the emergency response and strong emergency preparedness policies *before* the emergency strikes. When the foundation on which to build a health response is weak or non-existent, lessons learned during crises are quickly forgotten, crisis managers grow complacent and emergency preparedness is neglected.

Over the past 30 years, there has been a major shift in emergency management strategies. It is becoming increasingly clear that while humanitarian response efforts remain crucial, strong community-based risk reduction and emergency preparedness programmes are critical to mitigate the effects of crises and foster sustainable development.

Emergency preparedness has traditionally focused on stockpiling relief goods and ensuring the availability of basic services. In most countries, political commitment and resources are still overwhelmingly concentrated on these short-term emergency contingencies. However, there is now a greater recognition of the need for comprehensive public policies on disaster risk reduction and emergency preparedness and response, focusing on communities most at risk.

The 10 countries with the highest under-five mortality rate in the world and per capita government spending on health



Source: World Health Statistics 2008

Preparedness is essential in securing the right to life with dignity. States bear primary responsibility for protecting their populations and ensuring a dignified life, but the modern approach to preparedness extends well beyond sectors traditionally involved in relief efforts, such as civil protection forces, emergency offices and humanitarian organizations. Communities need to work closely with local authorities, public organizations and relevant parts of the private sector to strengthen their emergency preparedness capacities and their ability to manage the consequences of various risks. The health impact of emergencies can be substantially reduced if both national and local authorities and communities in high-risk areas are well prepared and able to reduce the level of their vulnerabilities and the health implications of their risks. The challenge is to put in place systematic capacities such as legislation, plans, coordination mechanisms and procedures, institutional capacities and budgets, skilled personnel, information and public awareness and participation that can measurably reduce future risks and losses.³⁶

A good emergency preparedness policy recognizes both individual and collective rights. It maps hazards, communities and vulnerabilities in the geographical area; sets out relevant development, health, and environmental policies; and documents existing legislative and organizational responsibilities and resource limitations. Accepted emergency management concepts include a comprehensive approach; an all-hazards approach; a multisectoral and intersectoral approach;³⁷ and community participation. Emergency preparedness and disaster risk reduction are core responsibilities of the ministry of health. They are not transient or short-term, but permanent. Therefore, a corresponding structure (office, unit, or department) must be institutionalized within the ministry of health of each country.³⁸

The policy and technical framework for emergency management is set at national level, but is executed at the local level. Communities bear the brunt of disasters and must be fully involved in planning for those hazards for which they are at risk.

Conclusion:

Disaster risk reduction and emergency health preparedness mirror the public policies reform set out in the PHC renewal process: the integration of health sector plans and programmes, a multisectoral approach, partnership and coordination between communities and levels, and the importance of community involvement. Strong primary health care systems build community resilience and provide the foundation for effective emergency preparedness and response. Disaster risk reduction and health emergency preparedness, response and recovery programmes must be integral parts of sustainable, inclusive and multisectoral policies which are key to moving towards an effective PHC renewal process.

Crises are opportunities to reinforce and promote public policy reforms: promoting and managing essential medicines

Policies related to essential medicines are severely challenged during crises. A common yet mistaken belief in acute emergencies is that any type of medicine is better than none at all. Experience has shown that the cost of managing donations of medicines is high, and often exceeds the value of the donated items. The safe disposal of inappropriate, unwanted or expired medicines creates huge logistic and environmental problems. The unregulated flow of humanitarian donations can override public policies that aim to make safe, low-cost essential medicines available and to rationalize their use. Moreover, the value of the donated medicines may be higher in the donor country than on the world market. In these cases import taxes and overheads for storage and distribution can be unnecessarily high, and the donation's inflated value may be deducted from the government's budget for medicines.³⁹

The Interagency Emergency Health Kit (IEHK) has been designed to overcome these concerns. It includes enough essential medicines and medical supplies to meet the needs of 10 000 people for three months. Although the IEHK is primarily intended for displaced populations without medical facilities, it can be used to re-supply PHC facilities when normal supply systems have broken down.⁴⁰ The IEHK, jointly developed by UN agencies, the International Committee of the Red Cross and humanitarian NGOs, is a model of inter-agency collaboration and a **tool to promote an essential medicines policy**.

The Supply Management System (SUMA) developed by WHO's Regional Office for the Americas (WHO/PAHO) has been designed to help national authorities bring order to the chaos of uncoordinated humanitarian assistance. SUMA is a software-based system that helps disaster response teams consolidate and share information on emergency supplies, improve transparency and record and monitor the distribution of undocumented items, particularly unsolicited donations. It has been widely used in various disasters in South America.⁴¹

Emergencies and crises: risk management

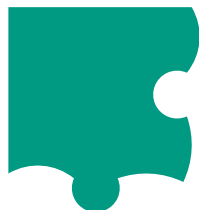
In line with widely accepted national and international approaches, WHO's risk reduction and emergency preparedness strategy is based on an "**All-Hazard / Whole-Health**" concept:

- **All-Hazard** entails developing and implementing emergency management strategies for the full range of likely risks and emergencies (natural, biological, technological and societal). Different hazards and emergencies can cause similar problems in a community; and measures such as planning, early warning, intersectoral and intrasectoral coordination, evacuation, health services and community recovery are usually implemented along the same model adopted by the community regardless of cause.

- A **Whole-Health** approach has to be adopted. Countries and communities at risk cannot afford to have parallel planning and coordination systems for each category of health risk. Technical leadership may vary but emergency planning processes, overall coordination procedures, surge and operational platforms should be unified under one emergency preparedness and response unit. Health sector plans can then be effectively coordinated with those of other sectors as well as with the designated national multisectoral emergency management agency. In addition to death and injury, other considerations must be included in the health plan. It is recommended that emergency preparedness plans include – in addition to the common coordination, information tools and support services – environmental health (including water, sanitation and hygiene); management of chronic diseases (including mental health); maternal, newborn and child health; communicable disease control; nutrition; pharmaceuticals and biologicals and health care delivery services (including health infrastructure). Other specialized services may be included for preparedness and management of specific risks. Another key aspect of the Whole-Health approach concerns the necessity to include, starting from the planning phase, health institutions and capabilities available in the private sector, military medical services, national Red Cross/Red Crescent societies and other nongovernmental organizations.

ADDRESSING HEALTH INEQUITY

Synergy three: using humanitarian health action to move towards universal coverage



People affected by humanitarian crises expect an equitable humanitarian response.

However, crises can amplify pre-existing inequities and/or result in new problems of social injustice.

Disasters are not random killers. There is a strong link between natural disasters and poverty. Those hardest hit are often the most vulnerable, including the poor, women, children and the elderly.⁴² Moreover, the poorest countries are the most vulnerable to natural disasters.⁴³ More than 90% of deaths caused by natural disasters occur in developing countries, and least developed countries suffer most of all.⁴⁴ Although just 11% of people exposed to natural disasters live in low human development-classified countries, they account for more than 53% of recorded disaster-related deaths.⁴⁵

“Cities are often particularly hard-hit by disasters. The increasing concentration of the world’s population in urban areas means the lives of millions of civilians are at risk each time an earthquake, hurricane or other natural disaster occurs. A large-scale natural disaster can have devastating results for the poorest and most vulnerable segment of the population, including IDPs living in disaster-prone areas on the outskirts of mega-cities, where they have little access to basic services.”⁴⁶

The mere fact of displacement can result in significant inequities in the health status of populations: for example, crude mortality rates in humanitarian emergencies tend to be particularly high among IDPs. Paradoxically, however, IDPs and refugees sometimes have better access to health services than the host population.⁴⁷

In crises, the health of women, girls, boys and men is affected differently. Available data suggest there is a pattern of gender differentiation in terms of exposure to and perceptions of risks, preparedness, response, and physical and psychological impact, as well as capacity to recover.⁴⁸

There are striking inequities in the distribution of humanitarian aid: 63% of the total amount of funds donated under the Consolidated Appeal Process in 2008 was concentrated in five of the more than 20 countries that appealed for funds. Only three countries received over 80% of the amount they requested for the health sector.⁴⁹

The roots of inequities lie in social conditions outside the health system’s direct control. These roots must be tackled during the humanitarian response through a well-informed analytical process, resulting in intersectoral and cross-governmental action. However, emergency response strategies often focus heavily on technical aspects, with short-term success being paramount. Many decisions are taken by technical experts who typically intervene in the same way everywhere, without consulting those most affected by the emergency, speed being the declared overriding concern. Humanitarian action remains vertical; health professionals work with beneficiaries often in a paternalistic way, despite some attempts to involve communities after the initial phase of the crisis.⁵⁰ This non-consultative approach risks exacerbating existing inequalities and ignoring the real needs and rights of the affected population.

Key actions towards achieving equity in humanitarian crises include universal coverage and access to humanitarian aid.

The concept of coverage in humanitarian assistance is subject to various factors strictly related to the crisis context. Coverage requires the availability of services, the elimination of barriers to access, and social protection. The term “humanitarian space” has been defined as “a space of freedom in which humanitarian actors are free to evaluate needs, free to monitor the distribution and use of relief goods, and free to have a dialogue with the people” (Wagner 2005). This *potential* humanitarian coverage

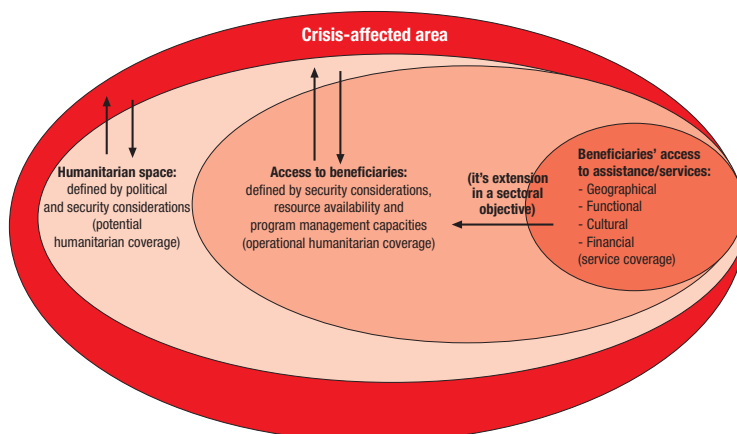
reflects the general freedom of movement and access to beneficiaries allowed by security and political considerations. Ideally, the entire affected area/population should be “covered”.

The term “operational humanitarian coverage” defines the range of operations allowed within the constraints of available resources. It is influenced by security considerations, and, most of all, by the sum of programme management capacities and coordination efforts of all humanitarian actors.

Targeted population coverage, or service (*programme*) coverage is defined in terms of numbers of beneficiaries, but also of space and time (e.g. proximity, speed, continuity). Relief that reaches only a low proportion of the affected population, or only irregularly, or that forces them to leave the area, can only partly meet the objective of saving lives and reducing suffering. In general, indicators of programme coverage and performance need to be interpreted in the context of the overall picture. While it is important to know what proportion of people in need of a service and living within the programme catchment area actually benefit from the service, it is equally important to understand the size of the programme area within the overall operational and humanitarian coverage.

Programme coverage implies a given minimum standard of service provision, and effective access by the population. In other words, just because a clinic has been set up in a camp, one cannot conclude that the camp is “covered” or that coverage in that camp is 100%. Thus, programme coverage is the proportion of people in need of a service and living within the stated catchment area of the programme, who benefit from that service. The minimum service is defined according to given minimum standards of quality and timeliness.

Graphic representation of various types of coverage in crisis-affected areas (Loretti 2005)



Conclusion:

Humanitarian health action reflects the PHC perspective on universal coverage as a fundamental, though not exclusive, step to promote health equity. Universal coverage in humanitarian health action means that service coverage is extended to all crisis-affected areas.

LEADERSHIP

Synergy four: reinforcing leadership for effective emergency risk management



The public sector requires strong leadership to steer disaster risk reduction and emergency preparedness and response efforts. This function should be exercised through collaborative models of policy dialogue with multiple stakeholders.⁵¹

Crises, particularly those that are protracted or repeated, challenge leadership and weaken states. Central leadership can be perceived as weak or as illegitimate, and other (international) actors may play parallel leadership roles that may further undermine national governance.⁵² In addition to the traditional humanitarian agencies, military forces, private contractors and other non-state actors including national and international nongovernmental organizations, national faith-based organizations are playing an increasingly important role in high-profile conflicts and disasters.⁵³ Weak governments are often incapable of ensuring basic security, fail to provide basic services and economic opportunities, and are unable to garner sufficient legitimacy to maintain the confidence and trust of their citizens.⁵⁴

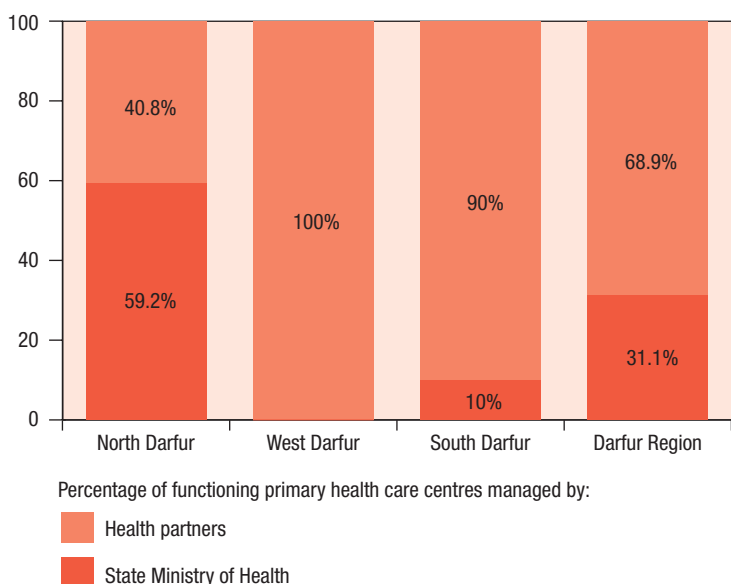
Alternatively, crises can result in authoritative, centralized leadership that reduces participation, negotiation and policy dialogue. Furthermore, leadership is often compartmentalized, with every aspect of economic and social life treated separately and in a simplified, non-communicative way.⁵⁵

States have ultimate responsibility for disaster risk reduction and emergency preparedness and response. However, particularly in conflict or post-conflict situations, when the state is very weak or even non-existent in parts of the country or is itself driven by political conflict, international humanitarian agencies may be required to temporarily fill a governance vacuum. In these cases, international humanitarian actors, particularly United Nations agencies, may not only take the lead in responding to priority needs but may also assume overall policy leadership, overriding local authorities and establishing temporary humanitarian governance as was the case, for instance, in Kosovo and in Timor.

In early 2008, only 59.2% of the 76 functioning primary health care centres (PHCCs) in North Darfur and 10% of the 50 PHCCs in South Darfur were managed by the Ministry of Health. None of the PHCCs in West Darfur was managed by the Ministry of Health.

Humanitarian governance has been defined as “the use of international humanitarian law and human rights instruments to govern the behavior of state and non-state organizations in conflict zones in a way that protects the lives and livelihoods of affected populations”.⁵⁷ It is often implemented within the framework of

Management of primary care services in Darfur



integrated missions in an attempt to maximize available United Nations resources and expertise. The United Nations system-wide response implemented during integrated missions includes peacekeeping, human rights, development and humanitarian assistance and reflects the understanding that development and human rights issues are inseparable from peace and security and the creation of sustainable peace.⁵⁸

When national leadership is weak or absent, the coordination of humanitarian stakeholders substituting state functions is crucial. In June 1992, the United Nations created the Inter-Agency Standing Committee (IASC) as a unique forum for coordination, policy development and decision-making among United Nations and non-United Nations humanitarian partners. In the event of a complex emergency or the deterioration of an existing humanitarian situation, the United Nations Emergency Relief Coordinator, on behalf of the Secretary-General and after consultation with the IASC, designates a Humanitarian Coordinator for the country. The Humanitarian Coordinator's responsibilities include advocating with relevant parties for the application of humanitarian principles and overseeing inter-agency strategic planning for that country. The IASC works through the CAP, which allows national, regional and international relief systems to jointly mobilize resources for major or complex emergencies that require a system-wide response. The CAP has become much more than an appeal for money. In addition to being an indispensable tool that allows aid organizations to plan, implement and monitor their activities together, it is now the main policy document that guides the various stakeholders. In situations where national health policies have ceased due to crises, the health strategy in the CAP comes closest to a policy reference against which various services providers can align their interventions.

Integrated missions, the IASC, the Humanitarian Coordinator system and the CAP are all arrangements for strengthening or rebuilding inclusive leadership in the response to humanitarian crises. The reality, though, is that links between the humanitarian community and national authorities are often weak, and national stakeholders are only marginally involved.

Conclusion:

In implementing PHC renewal, disaster risk reduction and health emergency preparedness and response programmes, it is essential to promote an inclusive leadership empowering all groups in society through fair representation in decision making, bearing in mind that community action cannot be dissociated from the state's (or whoever has taken on the overall leadership role) responsibility to guarantee equal access to humanitarian relief during crises as well as equal participation in defining disaster risk reduction and emergency preparedness plans.⁵⁹ Strong but inclusive negotiation-based leadership is essential to make health authorities more reliable and replace disproportionate reliance on command and control on the one hand and disengagement of the State on the other.

PHC renewal and humanitarian action: moving towards a rights-based approach

This report discusses how PHC renewal can contribute to the aims of humanitarian health action and improve its processes. This orientation of humanitarian health action towards a PHC approach strongly aligns with another major shift in this field – viewing humanitarian health action not just in terms of simply meeting needs but rather as a means to promote social justice and fulfil the right to health.

This understanding of humanitarian health action recognizes that social justice has a profound impact on the way people live and die⁶⁰ and is linked to the protection, promotion and fulfilment of human rights. Health is a fundamental human right affirmed in a range of United Nations and WHO documents starting from the *Universal Declaration of Human Rights*. As part of this right, the precept that health services, goods and facilities must be provided to all without discrimination is a key principle for humanitarian health action as well as for PHC renewal.⁶¹ The right to health also includes a wide range of factors such as the right to safe drinking water and food, the right to an adequate standard of living, the right to access to information and the right to participation, all of which are echoed in PHC’s call for intersectoral action to address factors beyond the health sector.

The contexts where humanitarian health action is necessary are particularly difficult for the whole range of human rights. In natural disasters, experience has shown that, while patterns of discrimination and disregard for economic, social and cultural rights may already emerge during the emergency phase of a disaster, the longer the situation lasts, the greater the risk of human rights violations.⁶² Armed conflicts in the twenty-first century are characterized by violations of human rights and breaches of international humanitarian law. Denials of human rights and breaches of medical neutrality are potentially the main social determinants of health in countries in conflict.⁶³

Despite these difficulties, the adoption of a rights-based approach as the core of humanitarian action by many organizations in recent years fundamentally changes the “way of doing business” between humanitarian actors and the people they serve. “Victims” or “beneficiaries” become rights-holders, and humanitarian agencies become their advocates. This shift, while not universal in the humanitarian sector, is widely observable in organizational policy formulations. It is people-centred, empowering, universal and dignified.⁶⁴

These values strongly echo those of PHC. PHC reforms, which strive to give these values expression in the promotion and protection of health, are thus an important tool to realize a rights-based humanitarian health action. Paying attention to inequities and increasing social justice; increasing participation in the planning and provision of services; and taking care not to undermine existing services through fragmentation are directions that humanitarian health action has sometimes overlooked in the past. A rights-based approach informed by PHC reforms, as discussed throughout this report, can assist in remedying these past oversights.

Concluding statement

The strengthening of disaster risk reduction, health emergency preparedness, response and recovery is critical for the success and sustainability of PHC renewal and to ensure that health development gains are protected from the potential ravages and distortions of crises. At the same time, the success of humanitarian health action also depends on strong implementation of the PHC approach, in order to build community capacities and resilience and affirm the right to health. The health sector, supported by other sectors, can ensure that the integration of humanitarian health action in the PHC renewal process will mutually reinforce support for a community – and rights-based approach to health for the greater benefit of individuals and communities.

Way ahead

While this annual report fulfils its stated role of looking back on achievements and obstacles in 2008, it also serves to map out the major issues that will guide WHO's humanitarian activities for the year to come.

WHO's emergency preparedness and response strategy is set out in its Five-year programme (2009–2013) for strengthening WHO's institutional capacity for humanitarian health action. The strategy aims to improve WHO's emergency work by increasing its presence in the field, developing tools, standards and norms, establishing training programmes, reinforcing emergency administrative procedures and instruments, and strengthening collaboration with other United Nations agencies and key partners.

The strategy has two pillars. The first aims to improve WHO's institutional capacity for emergency response and recovery work, using the Health Cluster approach whenever possible. The second pillar focuses on improving WHO's ability to help countries prepare for emergencies and reduce the risk of disasters. This ambitious plan has at its heart the need to improve the health of millions of people, many of whom are among the world's poorest and most at risk whenever disasters strike.

Preparedness is central to WHO's emergency work in countries. In recognition of the importance of this issue, WHO is devoting World Health Day 2009 to the theme of health facilities in emergencies. Health centres and staff are critical life-lines in emergencies – treating injuries, preventing illnesses, and caring for the people in the community. The campaign is intended to spur efforts from all actors, particularly governments, financial institutions and donors, for greater investment in preparing health facilities and health staff to deal with emergencies.

WHO's key challenge in the years ahead will be to secure the flexible funding needed to develop and maintain the human resources, logistics and supply systems and financial, administrative and project management infrastructures to support timely and effective emergency response operations and to help Member States build national capacities for emergency preparedness and response. The importance of unearmarked funding cannot be underestimated. The entire humanitarian community – not just the health sector – must have access to flexible funds to be able to respond quickly and effectively to the inherent chaos and unpredictability of crises, when priorities may change by the day.

As head of the Global Health Cluster and coordinator of humanitarian health operations in the field, WHO is responsible for leading and coordinating emergency response efforts, providing authoritative, evidence-based guidance to ministries of health and other partners, ensuring gaps are filled and survivors are able to rebuild their communities. This responsibility must not be taken lightly. It obliges WHO to remain true to the humanitarian principles of humanity, neutrality and impartiality, and to provide true leadership to health partners during times of need.

End notes and references

1. *Quality and accuracy of disaster data: a comparative analysis of three global datasets*. Working paper prepared for the Disaster Management Facility, World Bank, Brussels CRED 2002.
2. For a disaster to be entered into the CRED database at least one of the following criteria must be fulfilled: i) 10 or more reported killed; ii) 100 or more reported affected; iii) declaration of state of emergency and; iv) call for international assistance. “Killed” is defined as persons confirmed dead and persons missing or presumed dead. “Affected” is defined as people requiring immediate assistance during a period of emergency; it can also include those displaced or evacuated.
3. The Uppsala Conflict Data Program (UCDP) collects information on a large number of aspects of armed violence since 1946. According to UCDP, an armed conflict concerns government and/or territory where the use of armed force between two parties, of which at least one is the government of a state, results in at least 25 battle-related deaths in one calendar year. The intensity variable is coded in two categories: **Minor**: At least 25 but less than 1000 battle-related deaths in a year. **War**: at least 1000 battle-related deaths in a year.
4. L. Harbom and P. Wallensteen (2008). *Patterns of major armed conflict, 1998–2007, Sipri Yearbook 2008*, Oxford University Press.
5. R. Garfield, J. Polonsky, unpublished, 2008.
6. WFP Annual Report 2007.
7. FAO (2008). *The State of Food Insecurity in the World 2008*.
8. *UNHCR Statistical Yearbook 2007*. Some 4.6 million Palestinian refugees under the mandate of the UN Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA) are not included in this figure. The UNHCR defines a refugee as someone who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.
9. UNHCR defines a protracted refugee situation as “one in which refugees find themselves in a long-lasting and intractable state of limbo. Their lives may not be at risk, but their basic rights and essential economic, social and psychological needs remain unfulfilled after years in exile. A refugee in this situation is often unable to break free from enforced reliance on external assistance.”
10. Internal Displacement Monitoring Center (2008). *Internal Displacement: Global Overview of Trends and Developments in 2007*.
11. WHO/EURO (2002). *Promoting Disaster Reduction in Europe, A Concept Paper and a Five-year Project Proposal*. G. Annunziata, Unpublished.
12. Each kit contains enough medical supplies to meet the health needs of 10 000 (ten thousand) people for three months.
13. These two kits, normally used together, provide enough material and medicines to meet the needs of 100 patients requiring trauma surgical care. Kit B is a complement to Kit A.
14. Each kit contains enough supplies to treat 200 severe or 400 mild cases of diarrhoea.
15. Guidelines provided included: the management of diarrhoeal diseases; dengue; leptospirosis; snakebites; the management of dead bodies; risk assessment of communicable diseases; and intersectoral rapid assessments.
16. The maternal mortality rate was 1355 per 100 000 live births in 2007.
17. Burkina Faso, Mali, Niger and Nigeria.
18. 1586 deaths from cholera were reported, with a case fatality rate of 5%.

19. Post-Nargis Joint Assessment report, <http://www.asean.org/21765.pdf>.
20. Angola, Bangladesh, Benin, Botswana, Burkina Faso, Cameroon, Chad, China, Comoros, Democratic Republic of the Congo, Eritrea, Guinea, India, Iraq, Kenya, Myanmar, Niger, occupied Palestinian territory, Pakistan, Rwanda, Sudan, Tajikistan, Togo, Uganda, Yemen and Zimbabwe.
21. Interagency Emergency Health Kits are designed to cover the basic health needs of 10 000 people for one month; Surgical and Trauma Kits are designed to cover 100 surgical operations; Interagency Diarrhoea Diseases Kits are designed to cover the medical needs of 700 patients with moderate to severe cholera and Shigella.
22. Although WHO's regular budget for its emergency work doubled in 2008, regular budget funds still only cover a fraction of needs.
23. There is no simple categorization of humanitarian crises. Various agencies have proposed a series of categories: see the Disaster Type List of the International Federation of Red Cross and Red Crescent Societies and/or the Handbook for Complex Emergencies of the United Nations Office for the Coordination of Humanitarian Affairs.
24. WHO (2008), *Global Assessment of National Health Sector Emergency Preparedness & Response*. WHO Geneva.
25. W Van Damme, W Van Lerberghe, M Boelaert. *PHC vs. emergency health assistance: a conceptual framework*. Health Policy and Planning; 17(1): 49-60. Oxford University Press 2002.
26. Humanity = the central importance of saving human lives and alleviating suffering wherever it is found. Impartiality = the implementation of actions solely on the basis of needs, without discrimination between or within affected populations. Independence = the autonomy of humanitarian objectives from other political, economic or military objectives. Neutrality = humanitarian action must not favour any side in an armed conflict or other dispute where such action is carried out.
27. *United Nations Millennium Declaration*, General Assembly Resolution A/RES/55/2, 18 September 2000.
28. High Level Forum on the Health MDGs (2004). *Achieving the Health Millennium Development Goals in Fragile States*. WHO and World Bank, Abuja 2004.
29. *Myths and realities in natural disasters*. WHO/PAHO.
30. Fritz Institute 2005.
31. IASC 2007.
32. T. Poletti, E. Sondorp, O. Bornemisza and A. Davis (2006). *Cost-sharing in Complex Emergencies: An Example of Inappropriate Policy Transfer*, Humanitarian Exchange No 26.
33. M. Thieren, A. Griekspoor. *Humanitarian Action and Primary Health Care*, unpublished draft 2007.
34. OCHA, WEF (2007) *Guiding Principles for Public-Private Collaboration for Humanitarian Action*. Geneva, December 2007.
35. WHO (2007). *Analysing disrupted health sector – Manual*. WHO Geneva.
36. WHO (2007). *Risk reduction and emergency preparedness. WHO six-year strategy for the health sector and community capacity development*. WHO Geneva.
37. WHO (1999). *Community Emergency Preparedness: A Manual for Managers and Policy-Makers*. WHO Geneva.
38. WHO (2006). *Report of WHO Expert Consultation: Emergency Preparedness for the Health Sector and Communities*. WHO Geneva.
39. WHO (1999). *Guidelines for Drug Donations – revised version*.
40. Inter Agency Emergency Health Kit 2006.
41. The WHO/PAHO Supply Management System – WHO/PAHO 2001.
42. *Myths and Realities in Natural Disasters*. WHO/PAHO.
43. C. de Ville, A. Griekspoor (2007). *Natural Disasters, the Best Friend of Poverty*. Georgetown Journal on Poverty and Law and Policy 14 (1): 61-94.

44. ISDR (2004). *Living with risk: a Global Review of Disaster reduction Initiatives*. ISDR 2004.
45. UNDP (2004). *Reducing Disaster Risk: a Challenge for Development*. UNDP Bureau for Crisis Prevention and Recovery.
46. UN HABITAT (2008). *State of the World's Cities 2006/7*.
47. K. Ranson, T. Poletti, O. Bornemisza and E. Sondorp (2007). *Promoting Health Equity in Conflict-affected Fragile States*. London School of Hygiene and Tropical Medicine, London.
48. IASC (2006). *Gender Handbook in Humanitarian Action*. IASC, Geneva.
49. OCHA (2008). Financial Tracking Service. Geneva.
50. ALNAP (2004). *Participatory Impact Assessment – A Guide for Practitioners*. ALNAP, London.
51. WHO (2008). *World Health Report 2008*.
52. WHO (2008). *Health Policy and Systems Research in Conflict-Affected Fragile States. Alliance for Health policy and System Research*. WHO, Geneva
53. Feinstein International Center (2006). *Humanitarian Agenda 2015: Principles, Power, and Perceptions, Preliminary Report*. Feinstein International Center, Medford
54. Derick W. Brinkerhoff – November 2008.
55. WHO (1999). *Decentralize Co-operation a New Tool for Conflict Situations*. WHO EURO, Copenhagen.
56. WHO (2008). Health Resource Availability Mapping System (HeRAMS) – WHO, Geneva.
57. S. Lautze, J. Leaning, A. Raven-Roberts, R. Kent, D. Mazurana (2004). *Assistance, protection, and governance networks in complex emergencies*. *Lancet* 2004; 364: 2134–41.
58. Perplexities and resistances still exist in putting together military operations and humanitarian action. These still constitute two clearly separate approaches to conflict and suffering. They are two clearly distinct forms of action which often manifest divergent objectives and priorities. The realities of humanitarian action, however, show that a compromise is possible. As a matter of fact, humanitarians are often using peacekeeping services for logistics, communication and security issues. It is likely that concerns about the structure of integrated mission are underpinned by a number of more substantial concerns such as lack of clarity and understanding of respective mandates.
59. WHO (2008). *Closing the gap in a generation – final report, commission on social determinants of health*. WHO, Geneva.
60. See note 58.
61. The right to the highest attainable standard of health (referred to as “the right to health”) was first reflected in the WHO Constitution (1946) and reiterated in the 1978 Declaration of Alma Ata and in the World Health Declaration adopted by the World Health Assembly in 1998. It has been firmly endorsed in a wide range of international and regional human rights instruments.
62. IASC (2006). *Protecting Persons Affected by Natural Disasters – IASC Operational Guidelines on Human Rights and Natural Disasters*. Geneva
63. WHO (2008). *Social determinants of health in countries in conflict – WHO Regional Publications, Eastern Mediterranean Series 32 – 2008*.
64. A. Carle, H. Chkam (2004). *Human Rights and Humanitarian Action – HPG Background Paper*.

Health Action in Crises

20 avenue Appia
1211 Geneva 27
Switzerland
Telephone: + 41 22 791 21 11
Facsimile (fax): + 41 22 791 31 11
E-mail: crises@who.int
www.who.int/hac or www.who.int/disasters

Regional Office for Africa

Emergency and Humanitarian Action
Cité du Djoué, P.O. Box 06
Brazzaville
Congo
Telephone: + 242 839 100 / +47 241 39100
Facsimile: + 242 839 501 / +47 241 395018
E-mail: khatibo@afro.who.int
<http://www.afro.who.int/>

Regional Office for the Americas

Emergency Preparedness and Disaster Relief
525, 23rd Street, N.W.
Washington, DC 20037
USA
Telephone: +1 202 974 3000
Facsimile: +1 202 974 3663
E-mail: eoc@paho.org
<http://www.paho.org/english/dd/ped/home.htm>

Regional Office for the Eastern Mediterranean

Emergency Preparedness and Humanitarian Action
Abdul Razzak Al Sanhoury Street,
P.O. Box 7608,
Nasr City, Cairo 11371, Egypt
Telephone: + 202 2276 50 00
Facsimile: + 202 2670 24 92 or 2670 24 94
E-mail: eha@emro.who.int
<http://www.emro.who.int/eha>

Regional Office for Europe

Disaster Preparedness and Response
8, Scherfigsvej
DK-2100 Copenhagen O, Denmark
Telephone: + 45 39 171 717
Facsimile: + 45 39 171 818
E-mail: gro@euro.who.int
<http://www.euro.who.int/>

Regional Office for South-East Asia

Emergency and Humanitarian Action
World Health House
Indraprastha Estate
Mahatama Gandhi Marg
New Delhi 110 002
India
Telephone: + 91-11-2337 0804
Facsimile: + 91-11-2337 9507
E-mail: eha@searo.who.int
<http://www.searo.who.int/>

Regional Office for the Western Pacific

P.O. Box 2932
1000 Manila
Philippines
Telephone: + 63 2 528 8001
E-mail: pesigana@wpro.who.int
<http://www.wpro.who.int/>