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TECHNICAL PAPER:

THE ROLE OF WHO IN EMERGENCIES AND DISASTERS

CONTENTS

THE ROLE OF WHO IN EMERGENCIES AND DISASTERS

[Agenda item 11 (c)]

1. INTRODUCTION

In recent years the international community has become increasingly alarmed by disasters, which, as they affect ever larger concentrations of population tend to have ever more destructive effects on humans. Disasters take many forms and occur as a result of one or more of a wide range of events, both natural and caused by man.

The duration of these events may range from a few seconds to many years. The severity of the effects of the events varies according to the degree to which humans have created an environment susceptible to damage; that is, an environment in which life and property are at risk.

1.1 Defining emergencies and disasters [1,2]

- **Emergency:** a sudden occurrence, demanding immediate action, that may be due to epidemics, to natural or technological catastrophes, to strife or to other man-made causes

- **Disaster:** any occurrence that causes damage, ecological disruption, loss of human life, or deterioration of health and health services on a scale sufficient to warrant an extraordinary response from outside the affected community or area.

- **Complex emergency:** a form of man-made emergency in which the cause of the emergency as well as the assistance to the afflicted is complicated by political considerations.

"Disaster", then, refers to not only the commonly perceived effects of sudden natural events: earthquakes, tropical storms, floods, volcanic eruptions, and so on, but also the effects of drought, crop failure, and other events that are slow to develop. "Disaster" is a term used also to describe the damaging or destructive effects of accidents in the course of man's normal activities. These include, but are not limited to radiation accidents, oil spills, atmospheric contamination and transport accidents. Finally the deliberate acts of man—war, civil strife and riot—bring about disasters.

There are many examples of such devastating events. In 1970, approximately 250 000 people died when a coastal area of East Pakistan (now Bangladesh) was flooded after a typhoon. Floods rendered two million people homeless in Khartoum, Sudan, in August 1988. In spring 1989, floods also affected 150 000 and 260 000 people in Djibouti and Yemen respectively [3].

In November 1994, Djibouti again suffered a very serious flood that affected nearly 80% of the population of the town of Djibouti, and hundreds of thousands of people were displaced. Floods also occurred recently in the Islamic Republic of Iran, Afghanistan and

Pakistan, causing huge losses, both human and economic. Drought has had serious consequences in Somalia. For example, between April and July 1987, approximately 600 died and half a million were severely affected. In June 1990, a devastating earthquake struck the northern provinces of the Islamic Republic of Iran, killing about 46 000 and injuring 110 000 people. The earthquake rendered 500 000 people homeless. Earthquakes have also struck Egypt and Afghanistan during recent years.

Man-made disasters are on the rise in the Eastern Mediterranean Region. In the past two decades, wars, civil strife and riots in Afghanistan, the Islamic Republic of Iran, Iraq, Lebanon, Somalia, Sudan, Kuwait, Yemen and occupied territories, including Palestine, have caused the death of thousands and injuries to even more. Some of the effects of warfare on health are shown in Table 1.

Table 1. The effects of warfare on health

General indirect effects

- *disruption of productive economic life*
- *disruption of food production and distribution*
- *disruption of family life*
- *creation of refugees and internally displaced*
- *psychological stress*

Direct effects on health

1. Health units

- *destroyed*
- *isolated from each other*
- *less accessible, e.g. under curfew, risk of ambush, besieged, etc.*
- *lack of supplies*

2. Health workers

- *disturbed areas abandoned, particularly by the more qualified professions*
- *disturbed areas difficult to post staff to*
- *dependent on foreign resources*
- *staff difficult to supervise*
- *prone to assault, demoralization and death*

3. Availability and utilization of services

- *disruption of communication and referral systems:*
  - *maternal and child health*
  - *home nursing care*
  - *monitoring and surveillance of communicable diseases, etc.*
  - *concentration of energy and efforts on the injured and rehabilitation*

Source: [4]

1.2 Disasters: on the rise

Disasters are becoming more frequent, more costly and more disruptive than ever before. Complex emergencies (which have political, social and economic origins), as well as natural disasters, are on the rise.

The increase in the global population, the deterioration of the environment, the widening of social and economic gaps, and regional and ethnic conflicts indicate that the problem will increase. Moreover, each disaster will bring more shattered lives, more separated families and more shaken communities—spiralling away from sustainable social and economic development. In 1987 it is estimated that war alone accounted for 2.2 million deaths in 20 developing countries (Table 2).

The number of people affected by natural and man-made disasters, including "complex emergencies", has increased in recent years. In 1994, while no accurate figures are yet available, it is estimated that globally the number may be as high as 250 million to 300 million people, among whom at least 40 million will have become refugees or internally displaced persons as a result of wars, complex emergencies involving internal strife or natural disasters. Complex emergencies appear to be on the rise, largely as a result of the ethnic and sociopolitical tensions that have surfaced in the post–cold war era [5,6].

Table 2. Twenty developing countries that suffered 2.2 million war deaths in 1987

Africa	Asia	South America
Angola	**Afghanistan**	Columbia
Chad	Cambodia	El Salvador
Ethiopia	India	Guatemala
Mozambique	**Islamic Republic of Iran**	
South Africa		
Sudan	**Iraq**	
Uganda	**Lebanon**	
	Myanmar	
	Philippines	
	Sri Lanka	
	Viet Nam	

Countries in bold are Member States of the Eastern Mediterranean Region
Source: [4]

2. THE IMPACT OF DISASTER

2.1 Impact on health

Disasters have a broad range of effects with a significant impact on health, ranging from the immediate care of victims to the medium- and long-term effects of the intermittent suspension of basic sanitation services, food shortages and the interruption of disease surveillance and control programmes. The death toll and the devastating effects on health as well as local and national economies are worst in the developing countries, which can least afford them.

There is a relationship between the type of disaster and its effect on health. This is particularly true of the immediate impact; earthquakes typically cause many injuries requiring immediate medical care, whereas floods and tidal waves cause relatively few. Sometimes the threat to health is not immediate but inevitable. For example, population density and movement and other environmental changes that increase the demand for water and food, with a subsequently higher risk of contamination, may lead to increased risk of disease transmission. Although epidemics generally do not result from disasters, in the long run, an increase in vector-borne diseases may occur in some areas because a disaster creates suitable breeding conditions for disease-bearing vectors.

The deleterious effects on health after a disaster do not all occur at the same time. In addition, they vary in importance within a disaster-affected area. Thus, casualties occur mainly at the time and place of impact and require immediate medical care, while the risk of increased disease transmission takes longer to develop and is greatest where there is crowding and standards of sanitation have declined [7,8].

2.2 Impact on population displacements

When large spontaneous or organized population movements occur, there rises an urgent need for relief services. People may move to urban areas where public services cannot cope, and the result may be an increase in morbidity and mortality. If much housing has been destroyed, large population movements may occur within and between urban areas as people seek shelter with relatives and friends, resulting in overcrowding in safer places and significant pressure on the public services in these areas.

2.3 Impact on food and nutrition

Food shortages in the immediate aftermath of a disaster may arise in two ways. Food stock destruction within the disaster area may reduce the absolute amount of food available, or disruption of distribution systems may curtail access to food even if there is no absolute shortage.

Generalized food shortages severe enough to cause nutritional problems do not occur after earthquakes. Flooding often damages household food stocks and crops, disrupts distribution and causes major local shortages. Food distribution, at least in the short term, is often a major and urgent need, but large-scale distribution is not always necessary.

2.4 Impact on mental health

Anxiety, neuroses and depression are not *acute* public health problems following disasters, and family and neighbours can deal with them temporarily. Whenever possible, efforts should be made to preserve family and community social structures. The indiscriminate use of sedatives and tranquilizers during the emergency relief phase is strongly discouraged. In developed countries, mental health problems are reported to be significant during long-term rehabilitation and reconstruction and may need to be dealt with during that phase.

2.5 Impact on the environment

The disruption as a result of disasters usually result in environmental pollution with serious health consequences.

For example, water pollution as a result of disasters can result in water-borne diseases such as cholera and gastroenteritis. Other infectious diseases transmitted by mosquitoes may increase as a result of the creation of breeding places for insects.

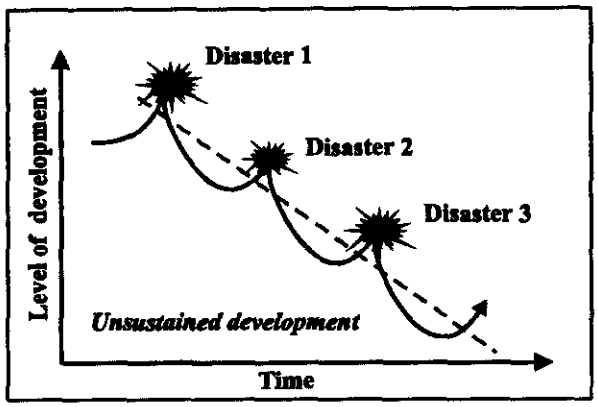
2.6 Impact on development

Fig. 1. demonstrates the impact of disaster on development in the absence of long-term emergency management. By contrast, Fig. 2 shows the expected effect of national emergency preparedness programmes on reducing the impact of disaster on development [9].

The money that is spent on emergency relief today is to some extent, being "diverted" from development programmes. It is estimated that the proportion of aid spent on disaster relief increased from 2% in 1989 to around 7% in 1994. If this trend continues, by the year 2000 we will be spending at least 12% of development aid on emergency relief.

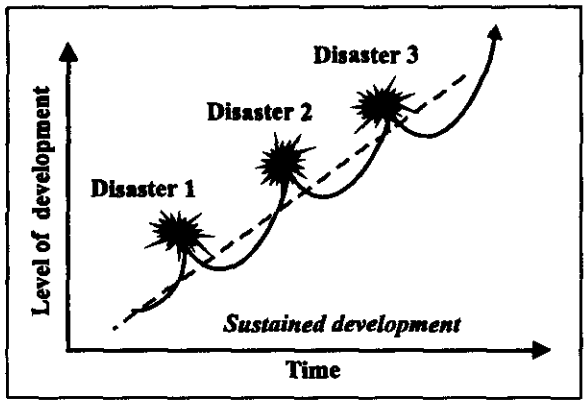
The dominant policy approach to disasters has been "crisis oriented", and disaster prevention and relief has not been seen as an integral part of development (Fig. 3). The general public tends to perceive disaster management in terms of the delivery of relief supplies and medical care. While these activities are important, they are not enough. Disaster management and development activities need to be streamlined and efficiently coordinated, particularly in a world of shrinking resources and rising demands.

Fig. 1. Disasters and development



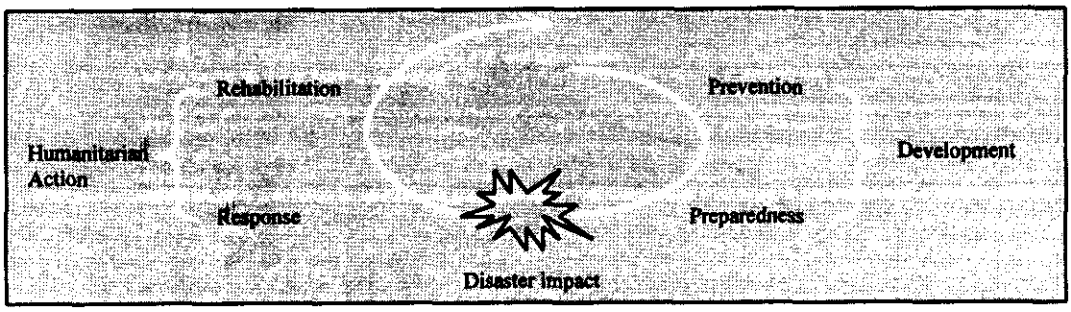
There is an overwhelming tendency to respond to disasters rather than anticipate and plan for them. An ad hoc response can lead to a downward spiral away from development [9].

Fig. 2. Emergency preparedness and development



By encouraging long-term emergency management (disaster prevention, emergency preparedness, relief and recovery that are compatible with national development), the frequency and/or impact of disasters can be lessened [9].

Fig. 3. Humanitarian action ↔ sustainable development



Emergency management and development are linked. Prevention and preparedness measures should be integrated in development planning, in order to minimize the impact of disasters. Response and rehabilitation are humanitarian activities that should contribute to sustainable development. Emergency management is a continuing process which is relevant not only at the time of the disaster impact, but as an integral part of sustainable development.

Source: [9]

2.7 Disaster management

In the 1980s, the scientific community realized that the answer to disaster management was not exclusively in relief. The answer lies in building up national capacities to deal with emergencies, starting with prevention, mitigation and preparedness, and going on to relief, rehabilitation and recovery (Figs. 4 and 5).

Fig. 4. Rapid onset disaster management continuum

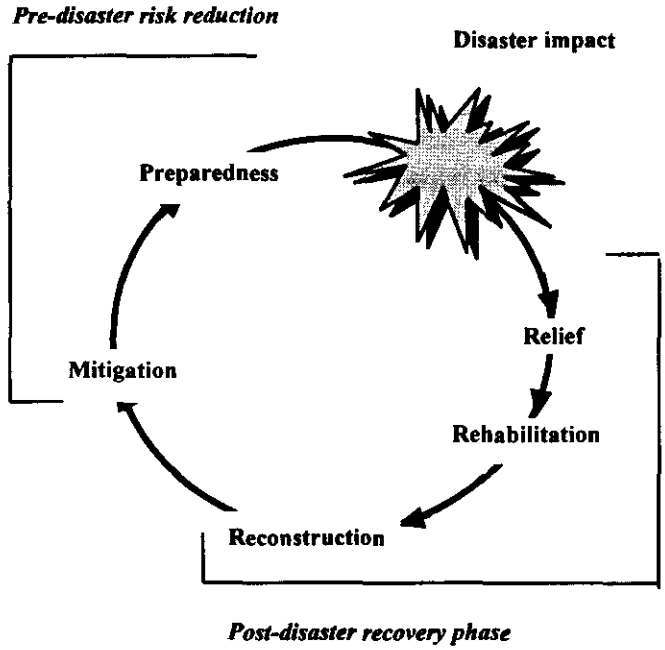
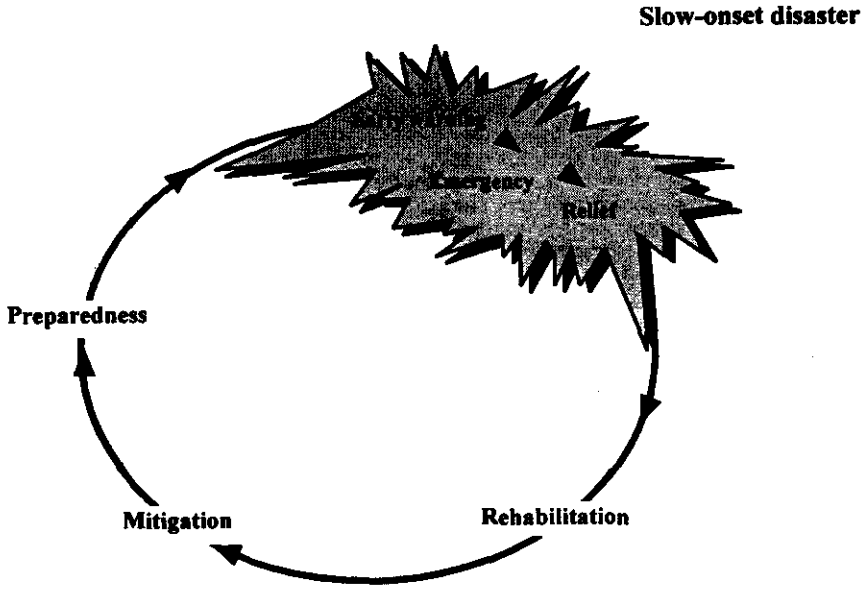


Fig. 5. Slow onset disaster management continuum



While acute natural disasters are threats to health and well-being in most parts of the world, many areas face disasters with slow onset and chronic duration. Predictably, the developing countries are affected the most by slow onset disasters such as malnutrition, epidemics, drought, war and civil strife. These disasters have strong man-made origins and are closely linked with social and economic development.

The health management of disasters has to be moved beyond rescue and short-term relief, to encompass the whole disaster process, from pre-disaster planning and preparedness to long-term rehabilitation

Emergency management based exclusively on disaster relief measures has disadvantages:

- it creates a culture of dependency among those receiving external assistance;
- disasters become repeat events, as root causes are not addressed;
- money and human resources are drained from external organizations providing assistance, causing professional burnout, high turnover and donor fatigue;
- resources are diverted from development projects to short-term relief, partly in response to pressure from public opinion;
- fragile ecosystems continue to be eroded; and
- mass movements of people are triggered.

3. THE ROLE OF WHO IN EMERGENCIES AND DISASTERS

3.1 How WHO's emergency relief activities are organized

Within the global efforts aimed at emergency preparedness and disaster relief in the United Nations system, WHO's primary responsibility is to assume the health coordination role under its mandate, taking advantage of its scientific and technical expertise in medicine, public health and health development. In asserting this role, WHO works primarily with the United Nations Department of Humanitarian Affairs, which was established in early 1992 in order to enhance coordination in complex emergency situations. As a member of the Interagency

Standing Committee (IASC) and the IASC Working Group, WHO has become increasingly active in United Nations emergency and humanitarian activities [2].

Since WHO's inception, its many technical programmes, such as those for communicable disease prevention and control, immunization, water and sanitation, mental health or essential drugs, have incorporated elements of emergency preparedness in specific activities for health development in Member States.

WHO formally established an emergency unit in the 1970s to coordinate the technical support of other divisions to regional offices for emergency preparedness activities at country level. In the 1980s, when natural disasters, "technological" disasters and complex emergencies increased in number and importance, Member States called on WHO to tackle disaster relief as well. Several World Health Assembly resolutions have been adopted to strengthen emergency response* With this in mind, the former Emergency Relief Operation division (ERO) of the World Health Organization was replaced in 1993 by the division of Emergency and Humanitarian Action (EHA) with a strengthened and more extensive mandate to handle health sector emergency and humanitarian activities, including the programme of safety promotion and injury control.

In the area of emergency preparedness, activities include institutional capacity building, policy-making and planning awareness building, technical advice and publication of relevant documentation, including guidelines and research on health emergency preparedness issues. Particular attention is also paid to emergency preparedness training activities in the health sector.

In the area of emergency relief and rehabilitation, EHA is responsible for assisting in the coordination of international response to complex emergencies and major natural disasters in the health field in close cooperation with other agencies.

In EMRO, the Coordination, Resource Mobilization and Emergency Relief Unit, through the Division of Health Policy and Management, is responsible for coordination of activities on emergency preparedness and response with other agencies, both within and outside of the Region including Headquarters and Member States.

After an emergency has been officially declared, the nature of WHO's involvement depends on the scale of the emergency. In small-scale emergencies—for instance, a natural disaster of limited intensity or an epidemic—WHO, through the national and regional office concerned, would assist the affected country in emergency management and in evaluating interventions for "lessons learned" in order to further strengthen the national and subnational emergency preparedness programmes.

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* United Nations General Assembly resolutions: 46/182, on strengthening of the coordination of humanitarian emergency assistance of the United Nations (19 December 1991); and 48/57, on strengthening of the coordination of humanitarian emergency assistance of United nations (31 January 1994); and World Health Assembly resolutions: WHA 46.6 on emergency and humanitarian operation (12 May 1993); WHA 46.39 on health and medical services in times of armed conflict (14 May 1993). WHA 47.28 on collaboration within the United Nations system and with other intergovernmental organizations: health assistance to specific countries (12 May 1994); and WHA 47.29 on Rwanda (12 May 1994). Resolution WHA 48.2 of 8 May 1995 (on emergency and humanitarian action) requested, *inter alia*, the Director-General to "improve WHO's internal coordination and its capacity to provide effective coordination of health sector activities in response to emergencies in the field."

In major or complex emergencies that are beyond the coping capacity of the affected country, WHO should respond to the health effects caused by the disaster and extend full assistance. In complex emergencies, where no national authority is left to manage the services needed, WHO should—within the framework of UN-coordinated humanitarian assistance—take full responsibility for directly planning, coordinating and putting into effect all necessary health-related humanitarian assistance.

3.2 The role and responsibilities of WHO in the field of emergencies and humanitarian action

The guiding principles for WHO's emergency preparedness and response programme are set out in resolution WHA 34.26. The resolution stresses that despite the undoubted importance of relief in emergencies, preventive measures and preparedness are of fundamental importance, and reaffirms that the organization should assume a leadership role in the health aspects of disaster preparedness. Resolution WHA 38.29 emphasizes the necessity for an integrated response to link emergency measures with long-term development and the need to intensify WHO's technical cooperation at country level to enable Member States to enhance their own disaster preparedness.

WHO emergency preparedness and response activities will help Member States to coordinate, implement and monitor health policies, infrastructure development and relief operations so that they meet the threats to health of wide-scale emergencies, such as epidemics, drought, famine, cyclones, floods, earthquakes, chemical pollution, civil unrest and armed conflicts.

Resolution EB95.R17, adopted by the Executive Board of WHO in January 1995, "requests the Director-General within available resources:

1. to continue to support the efforts of Member States to strengthen their capacity in the field of emergency preparedness so as to protect the development achievements of countries and reduce the vulnerability of communities at risk;

2. to seek extrabudgetary resources which will complement regular budgetary funds for this purpose;

3. to promote and support the development of regional and country emergency preparedness programmes;

4. to continue to promote and actively take part in establishing, with appropriate partners in the United Nations system, a comprehensive, integrated and institutionalized approach to disaster reduction with the objective of ensuring comprehensive support to country programmes and related technical activities;

5. to ensure the coordinated participation of appropriate WHO technical programmes in disaster reduction and preparedness;

6. to further strengthen the technical and structural capacity of regional and interregional emergency preparedness centres."

3.3 Emergency preparedness

In emergency preparedness, WHO considers it its responsibility to continue and further expand its traditional role of strengthening the capacity of Member States and promoting their preparedness for emergencies.

National emergency preparedness is of a developmental nature and therefore should follow normal WHO procedures. In fact, national emergency preparedness is an essential part of the work of WHO at country and regional levels and comprises five elements, all aimed at strengthening capacity and capability in the health sector's response to emergencies:

- the development of national legislation and national policy for emergency management (including emergency and disaster prevention, mitigation and preparedness as well as response, recovery and rehabilitation);
- the development of plans and procedures for emergency management and the coordination of emergency activities at national and subnational levels;
- the development of institutional and human resources for emergency management;
- the development of programmes for public awareness, public education and community participation in emergency management; and
- the collection, analysis and dissemination of information related to emergencies and disasters.

WHO's involvement in emergency preparedness received an important boost with the establishment of the International Decade for Natural Disaster Reduction (United Nations General Assembly resolution 44/236) in 1989. UNESCO and WHO are the only organizations in the United Nations system to have passed a specific resolution of their governing bodies (see resolution WHA 42.16) on the Decade, urging increased contribution to related national and international efforts. An interagency working group for the Decade was subsequently created, of which WHO is a member.

The WHO Representative, or the responsible officers in the Regional Office or at WHO headquarters, initiate action:

1. following the declaration of an emergency, if the Member State is not in a position to respond effectively;

2. when a government requests WHO to provide technical/material assistance to deal with an emergency;

3. when the Secretary-General and/or Undersecretary-General of DHA decides that interagency action is necessary and when a special coordinator/representative is designated;

4. when WHO early-warning mechanisms indicate that an epidemic is imminent.

3.3.1 The role of the WHO Representative

- to promote the setting up of an emergency preparedness country programme and to encourage the health sector to play a full role;
- to encourage the integration of the programme in the country's long-term social and economic development plans;
- to promote the development of the necessary expertise and technical tools;
- to advise the national authorities, and help to allocate WHO regular country budget resources to the programme;
- to keep the regional office and headquarters informed and adequately advised on country programme orientation and achievements;
- to inform the country about international trends and about opportunities for intercountry and international cooperation; and
- to participate actively in the work of the UN Disaster Management Team* at country level.

3.3.2 The role of the Regional Office

The Regional Office will have full responsibility for managing country and intercountry emergency preparedness programmes, which are essential for the success of any global emergency and humanitarian action undertaking. Its role will include:

- directing and monitoring WHO country offices in implementing the tasks described above and providing them with technical support;
- planning activities and organizing intercountry projects in support of country programmes;
- developing new project proposals for fund-raising (through headquarters) and monitoring and evaluating them.

3.3.3 The role of WHO headquarters

The role of headquarters concentrates on global activities such as UN interagency undertakings, supporting the UN International Decade for Natural Disaster Reduction (IDNDR), the development of a pool of experts and support of regional undertakings through:

- fund-raising for project proposals submitted by the regions;
- building an orientation strategy and guidelines for WHO emergency preparedness activities, mainly through regular interregional meetings, and developing a network of WHO collaborating centres; and
- collaborating with other agencies at international level in developing and disseminating information, publications and material on emergency management, in full cooperation with the regional offices and the network of WHO collaborating centres.

* The UN Disaster Management Team is an ad hoc multi UN agency team under the responsibility of the United Nations Development Programme that is convened whenever disaster is anticipated or strikes.

ASSESSMENT OF EMERGENCY PREPAREDNESS

WHO has developed a preparedness checklist to help countries and communities assess their level of disaster preparedness. The following questions can help assess disaster preparedness and provide a focus for health preparedness activities at regional, district and community levels.

1. Is there a national health policy regarding emergency preparedness and relief? Is this policy being implemented?
2. Is there a person within a country's ministry of health in charge of promoting, developing and coordinating emergency preparedness and relief activities?
3. Are emergency preparedness activities coordinated with the health sector, civil defence authorities and key ministries such as the ministries of the interior and agriculture?
4. What joint activities in emergency preparedness and response are undertaken between the ministry of health, United Nations agencies, bilateral organizations and nongovernmental organizations?
5. Are there operational plans for health response to natural, man-made or other emergencies?
6. Have mass casualty management plans been developed (both before and after hospital admission) at the national level as well as for individual hospitals?
7. What health and nutrition surveillance measures have been taken for the early detection and response to health emergencies? For example, have disaster-prone geographical areas and high-risk seasons been identified? Are early-warning and surveillance systems established and working? Has a national reference laboratory been established?
8. What preparedness steps have been taken by environmental health services to respond to emergencies and disasters?
9. Have facilities been identified and have safe areas been designated as temporary settlement sites in the event of disasters? What provisions have been made for health care? Specifically, what provisions have been made for general or special health services, staffing, supplies, water and sanitation?
10. What training activities are devoted to emergency preparedness and response in the health sector at national, regional and district levels? What other institutions or organizations are involved?
11. What resources are available to facilitate a rapid health response? Is there an organized communications centre in the ministry of health? Is there an emergency budget? Is access to transport or emergency medical supplies assured in the event of disaster?
12. Is there some kind of system for updating information on the key human and material resources needed for an emergency health response—for example, updated inventories of essential drugs, four-wheel-drive vehicles, etc.?
13. What opportunities exist to test the effectiveness of emergency plans through simulation exercises and drills?

Source: [10]

3.4 Emergency response

Articles 2(d) and 2(e) of the WHO constitution require it to "furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of governments" and to "provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups" These groups do not necessarily fall within political boundaries, nor do they always follow the classical distinction between soldiers and civilians. Those eligible for WHO emergency health assistance include people suffering from disease, injury or malnutrition, be they civilians, military personnel or refugees.

WHO's objectives in emergency response are to provide, where appropriate, initial relief assistance in the humanitarian health field in the aftermath of disasters; to ensure that health relief efforts are efficient, appropriate and effective; and to support and rehabilitate health care systems, emphasizing the primary health care approach as well as the need to provide special groups with essential health services. A primary aspect of WHO's relief efforts will be to ensure that, as far as possible, the initial medical relief structures are incorporated into the permanent infrastructure, in accordance with the principle that emergency assistance should be provided in ways that will be supportive of recovery and long-term development, as stated in United Nations General Assembly resolution 46/182.

3.4.1 The role of the WHO Representative

In the field of emergency response, the role of the WHO Representative (WR) is both primary and critical. He or she is expected to participate in the planning of emergency response programmes as well as to support, monitor and help coordinate emergency response activities in the health sector. When UN Division of Humanitarian Affairs (DHA) interagency missions are fielded, the WR forms an integral part of the WHO team. When inputs are required for appeals, the WR's office is usually responsible for the preparation of initial proposals. During the emergency phase, the WR coordinates the needed activities directly and simultaneously with the Regional Office and headquarters. If the situation requires redeployment of the available staff as well as reprogramming WHO country resources for emergency needs, the WR is in the best position to advise on this issue and can also request specific support from the Regional Office or headquarters.

Before and after the emergency, the WHO Representative participates actively in the UN Disaster Management Team and takes full responsibility for leading all health-related emergency response activities undertaken by the United Nations. Special procedures are under study to help the WHO Representative to fulfil this task, in line with those existing for other resident representatives of humanitarian agencies.

3.4.2 The Role of the Regional Office

Once an emergency has been officially declared, the Regional Office is responsible for initiating technical support activities at country and intercountry levels. This may include participating in needs assessment missions, providing technical support, elaborating plans of action, putting into action agreed relief projects and activities through the country offices as appropriate, and reporting back periodically to the Director-General.

3.4.3 The role of WHO headquarters

Headquarters, through the Division of Emergency and Humanitarian Action (EHA), is responsible for interagency coordinating activities. This involves collaborating with DHA in planning and conducting assessment missions and leading the health component part of such missions; finalizing the WHO components of consolidated appeals and attending donor meetings; clearing plans of action; monitoring and evaluation; and reporting to DHA and the donor community on activities undertaken by regional offices and WHO country offices.

At the request of the regional or country office concerned, EHA/HQ contacts other WHO divisions at headquarters or WHO collaborating centres to obtain technical support for regional activities. When necessary, EHA/HQ may invite regional and/or national staff to attend donor meetings.

In complex emergencies, WHO headquarters, through the structure that is being set up under EHA, is taking drastic steps to increase the Organization's capacity to play its normative role within the health sector, in the coordinated emergency response programmes that these complex situations increasingly call for. These steps include:

- Establishing an emergency task force expressly to deal with policy issues arising within the context of complex emergency management and to consider issues relating to WHO's association with its partners in this work.

- The organization of health emergency teams to assess the health status and needs of the affected populations at the start of an emergency and to give direction to the overall response called for in the health sector. These teams will normally be led by a WHO staff member and will be able to draw upon focal points designated in each region and in the relevant WHO technical divisions and programmes as well as to call on specialized consultants.

- The setting up of a network of senior emergency health coordinators, drawn from WHO as well as from other institutions, that will be on standby and ready to assume leadership for the coordination of health sector responses called for by complex emergencies.

3.4.4 Stockpiling drugs and supplies

Only 30% of drugs donated by the international community are suitable for emergency use. WHO has developed standardized emergency health kits and a global network of drug warehouses and suppliers to ensure that the right drugs are delivered on time during emergencies.

3.4.5 Emergency assessment missions

WHO works through the existing network at the national and local levels—which it has already strengthened through its preparedness programmes—in order to handle crises efficiently.

WHO provides in-depth assessment of the health sector following emergencies. It provides technical expertise as part of multidisciplinary missions.

3.4.6 Consolidated appeals

WHO emergency response programmes formulate appeals for the health component of emergencies, which are integrated into an overall UN consolidated appeal.

WHO communicates to donors through such appeals, through participation in joint UN agency press conferences and through regularly updated situation reports.

The activities undertaken at the various WHO levels should complement one another and fulfil the operational requirements for humanitarian assistance of the UN system, as directed by DHA. Engendering a team spirit based on full partnership will increase WHO's credibility in this field and will ensure maximum support for Member States in need. At the same time, the stronger role that WHO has now assumed in the emergency response activities of the international community will call for changes in overall operating procedures at regional offices and WHO country offices in order to guarantee a prompt and efficient reaction by WHO during an emergency.

An interregional task force on EHA, comprising representatives of the six Regional Offices and headquarters, has recently concluded its meetings and prepared a draft document, clarifying functions at various levels and developing more flexible administrative procedures during emergencies.

During the meetings, the task force agreed on new procedures to be used in declared emergencies and identified the provisions of the WHO Manual to be modified, added to or deleted with respect to personnel, finance and budget and supplies. In drafting those changes, the task force introduced as few changes as possible to the main parts of the Manual and regrouped the new procedures in Chapter XV.4 (WHO Action in Emergencies and Disasters). In revising Chapter XV.4, care has been taken to include only essential information that is specific to emergency situations.

It has been also decided to prepare an operational handbook that will include enough information (taken, in particular, from the full Manual) for managing the main components of emergency response (responsibilities, finance, supplies, personnel management, communications, security, etc.).

The expected benefits from the revision of the WHO Manual are:

- clearer procedures for announcing an emergency; and
- introduction of more flexibility, increased responsibility for WRs, speedier flow of resources and simplified procedures for ordering supplies.

3.5 Resource mobilization

In order to ensure the long-term sustainability of technical support to intercountry and country efforts in establishing national emergency preparedness programmes, funds will need to be allocated from the regular WHO country budget and from regional and intercountry sources for this purpose.

WHO mobilizes resources for relief, recovery and rehabilitation of the health sector through:

1. resource mobilization through the DHA interagency consolidated appeal process;

2. resource mobilization through "WHO Appeals" or through special initiatives for emergency preparedness;

3. resource mobilization through the submission of project proposals by WHO Representatives to potential local donors for funding;

4. programming of emergency response funds;

5. reprogramming of regular budget funds to meet emergency needs; and

6. the DHA Central Emergency Revolving Fund (CERF).

It is recognized throughout the UN system that a severe shortfall in financial resources increasingly affects its humanitarian response capabilities and that overall donor funding is often weak. This situation will call for special fund-raising mechanisms to be devised to cope with emergencies, whenever they may arise.

4. WHO/EMRO EXPERIENCES IN COPING WITH EMERGENCIES IN THE REGION

The target of EMRO's disaster management activities, through the implementation of national emergency preparedness and response (EPR) programmes at country level, is to minimize human and material loses by ameliorating human behaviour through awareness, training and the optimal use of local and national resources. It has also as its target, the attainment of full collaboration between the government, the community, individuals and scientific research centres within each country.

WHO/EMRO activities and achievements in the Region, especially EMRO's experience in coping with emergency situations in Afghanistan, Somalia, Yemen and Sudan, are good examples of how WHO can and should work under very harsh circumstances [11-13].

4.1 Afghanistan

The World Health Organization in collaboration with the Afghani Ministry of Public Health developed and designed a regionally based health emergency relief programme and a programme to rehabilitate the health care system of the country. A regional emergency health

coordination committee chaired by the regional public health director has been established in each region of the country.

The Office of the WHO Representative for Afghanistan, through its eight suboffices inside the country, is providing emergency health assistance to local populations, returnees and displaced persons. Its work includes provision of emergency medical supplies and medical equipment, support for reconstruction of health facilities, training of health workers, assistance for disabled people, activities to improve environmental health, control of such priorities as malaria, tuberculosis and diarrhoeal diseases and support for health information systems and primary health care.

Afghanistan has suffered a major cholera outbreak and acute diarrhoea outbreaks in the past three years. In collaboration with national and local authorities, UNICEF and nongovernmental organizations (NGOs) WHO established cholera committees in all eight regions of the country; a national plan of action against cholera was prepared and implemented; thousands of health personnel and community leaders were trained; guidelines on diarrhoea prevention and treatment and chlorination of wells were distributed; a coordinated social mobilization and health education campaign using the BBC World Service's "New Home New Life" programme and local radio and TV stations was carried out; wells in affected cities were chlorinated; and supplies and equipment from WHO and other agencies were distributed.

In the rehabilitation and reconstruction field, WHO, in collaboration with other agencies and NGOs, has completed the rehabilitation of the piped water distribution system in Kandahar city, which benefits 350 000 residents. The rehabilitation of the piped water system in Jalalabad started in 1995 and is expected to be finished in 1996. When this latter project is finished, more than 300 000 residents will have access to safe drinking water. WHO is also planning to restore piped water supply systems in some other provinces of the country.

The WHO Representative was instrumental in helping to obtain a cease-fire between the warring factions, known as the Health Cease Fire, in order to organize three rounds of intensive immunization in late 1994 and early 1995. The cease-fire continued more than two months after the campaign thus putting in action the concept of Health for Peace.

During the three rounds of the campaign 2 317 991 of children under five years, and 807 342 children under two years were immunized against poliomyelitis and measles respectively. Also 740 712 women of childbearing age were immunized against tetanus.

One of the outstanding achievements of the Office of the WHO Representative for Afghanistan with support of the Regional Office and headquarters is extrabudgetary fund-raising for the implementation of activities in the country [14].

4.2 Kuwait

WHO launched a three month emergency plan in Kuwait in April 1991 to address the most urgent health needs of the country after the Gulf crisis. Among the areas it focused on were: rehabilitation of the health care infrastructure; surveillance of prevailing environmental hazards and their health impact; restoration of environmental control systems; immediate

provision of technical support, drugs and other supplies; establishment of a special programme to deal with post-war psychological trauma; restoration of the pre-war informatics system; establishment of a coordinated mechanism for the repair and maintenance of modern equipment required for running diagnostic facilities and blood banks; and re-equipment of emergency medical services, particularly ambulance services.

4.3 Islamic Republic of Iran

Over 40 000 persons are believed to have been killed when a cataclysmic earthquake struck the northern part of the Islamic Republic of Iran on 21 June 1990. WHO made available $100 000 and 8 tonnes of supplies, mainly in the form of WHO medical kits. The Regional Director additionally allocated $50 000 for urgent medical needs not met by donors. The Regional Office also contacted other donors to help assist in this tragedy.

4.4 Iraq

In February 1991, a joint WHO/UNICEF mission visited Iraq, during which time it delivered 54 tonnes of emergency medical supplies for mothers and children and ascertained the health care needs of the civilian population, especially those most vulnerable. Three EMRO staff members represented WHO. Since then, WHO has been continuously involved in the provision of emergency medical supplies to Iraq. Several missions were sent to assess the health situation, and efforts were made in order to mobilize funds to meet the cost of the required emergency supplies.

In Iraq, WHO, both headquarters and EMRO are making all possible efforts to provide the maximum possible emergency and humanitarian assistance. During 1995, these efforts included: rehabilitation of the chlorine plant in Basra; strengthening of malaria control activities; conducting a study on the trend of twelve infectious diseases over a period of five years; studying the effects of sanctions on health status; and streamlining demands and activities to optimize the use of resources and to strengthen coordination with other UN agencies. Also during 1995, the Regional Director paid a visit to Iraq. The Regional Director has made all possible efforts to alleviate the very grave health situation in Iraq. His efforts included contacts with Member States, NGOs and other donors requesting their assistance to provide the Iraqi people with highly needed essential drugs.

4.5 Palestine

The Ministry of Health of the Palestinian Self-government Authority continued the process of institutional capacity building and development of appropriate health policies and plans of action. Several missions were mobilized by headquarters and EMRO on request to assist in carrying out needs assessments and making recommendations for development of national plans of action and training of health personnel in various health spheres, including disease control, information systems, management, nutrition, essential drugs, nursing and environmental health.

Health services in the Gaza Strip and the West Bank continued to be offered by four major providers: the Ministry of Health of the Palestinian Self-government Authority, the United Nations Relief and Works Agency (UNRWA), the nongovernmental sector and the

private sector. UNRWA is also active in the Palestinian refugee population. Since October 1993 the Agency has maintained 20 ongoing health activities and completed another 11 projects, the majority in the Gaza Strip and West Bank.

Funds were also secured under the Peace Implementation Programme to implement projects for construction of additional health and maternal and child health centres, renovation and upgrading of existing facilities as well as to implement environmental health projects.

4.6 Somalia

WHO has been continuously actively involved in emergency operations in Somalia since the first Special Emergency Programme for the Horn of Africa (SEPHA) Appeal, launched in January 1992.

WHO emergency activities for Somalia have been implemented through WHO regular budget funds supplemented by voluntary contributions raised under several appeals.

WHO has established the Somali central pharmacy warehouse in Mogadishu and four satellite warehouses. This programme, with support from nongovernmental organizations (NGOs) and international donors, provided more than 80% of the drug and medical supplies used in Somalia during the emergency phase. The central and four satellite warehouses now continue to provide basic essential drugs to some 123 health care settings. WHO is encouraging other organizations to reduce the range of drugs provided to those noted in an approved essential drugs list for Somalia. WHO is now refocusing its activities on the development of treatment guidelines, training for the rational use of essential drugs and for coordination of the essential drugs supply system in Somalia.

WHO's technical, material and training support to health laboratory and blood transfusion activities has been successful. These laboratories are a critical component of an epidemiological surveillance system and are essential for the monitoring of trends of common diseases and the early detection of cholera. WHO has established blood banks, a centre for epidemiological and nutritional surveillance and a central reference laboratory.

A cholera epidemic occurred throughout 1994 and early 1995. During this time WHO assumed its role of technical coordinator in controlling this epidemic, in collaboration with NGOs, UNICEF and the World Food Programme. As part of WHO's cholera preparedness plan, extensive training has been given to Somali professionals in the management of epidemics, laboratory analysis of water and stool samples, and the treatment and management of acute diarrhoea. WHO is attempting to stockpile sufficient initial quantities of oral rehydration salts (ORS), Ringer lactate and other cholera related supplies in satellite warehouses throughout Somalia.

In view of the existing nutrition problems in various parts of Somalia and the projected structural food deficit, WHO is active in the nutrition sector. In connection with other UN agencies, WHO has strongly recommended early focused intervention to prevent what could become a new nutrition emergency in Somalia. Such interventions, in addition to increasing the availability and accessibility of food, include measures to reduce and control acute diarrhoea,

intestinal parasitic diseases and childhood diseases. WHO fosters standardized and approved nutrition assessment methodologies and therapeutic feeding programmes through the distribution of guidelines and training along with technical supplies to both international NGOs and Somali-run assessment and/or therapeutic feeding programmes.

4.7 Sudan

WHO is executing a project in Sudan entitled "Strengthening the capacity of the Ministry of Health in emergency preparedness and response". This project was started in 1990 for period of two years and then it was extended until December 1995. UNDP Sudan is the funding agency, and the federal Ministry of Health (MOH) is the implementing agency of this project. A tripartite (WHO/UNDP/MOH) review of the project was held on 28 January 1996 in Khartoum, and it was recommended that UNDP extend its financial support to the project until December 1996.

This project is aimed to strengthen the capacity of the federal Ministry of Health to improve coordination of EPR activities within the ministry and with external agencies, to establish a functioning health information system related to preparedness and response in health emergencies to support PHC activities and to introduce measures for strengthening EPR through existing health programmes.

The major project achievements are:

- creation of a surveillance system able to produce hazard mapping and risk analysis;
- creation of a radio network with an increase from 12 sets to 42 during the project, with 15 further sets being installed;
- an early warning system for emergencies at the federal level and in the states;
- improved capacity for a timely response to emergencies;
- links between the ministries concerned and with other agencies have been strengthened;
- production of a manual on EPR for health workers and NGOS;
- creation of a national committee for EPR consisting of high level authorities from ministries of health, education, interior, information and the civil defence council;
- training of state level coordinators. Nineteen of the 26 states now have an EPR focal point.

The EPR project has had a major and successful role in several emergencies; for example, improved management of the 1993/94 floods, flood risk mitigation in Kassala and Blue Nile states, mass immunization against cerebrospinal meningitis, and mass yellow fever immunization in at least high risk areas.

4.8 Yemen

During the rebellion which occurred in Yemen, WHO was the first agency that provided support to the government. This support started three hours after the first air raid on the capital, Sana'a. Because the country was suffering from a shortage of drugs, the WHO Representative was authorized to purchase drugs from the local market while WHO/EMRO and WHO/HQ airlifted supplies of drugs. The WHO Representative resisted leaving the country and remained

to coordinate all efforts to support the Ministry of Public Health and the civilian population. This enhanced the reputation of WHO. The WHO Representative acted as coordinating officer for a time when the UNDP resident representative left the country. He assisted in the preparation of the DHA appeal for international support for Yemen. The WHO Representative presented the appeal in Sana'a and he contacted the embassies concerned for support, either directly or through EHA, DHA or EMRO.

5. RECOMMENDATIONS

Member States should:

5.1 Confirm their political commitment to reduce their vulnerability to disasters and take necessary action at the highest level.

5.2 Develop comprehensive national disaster management plans, if not already existing, with emphasis on disaster reduction, and encourage continued mobilization of domestic resources for disaster reduction activities.

5.3 Establish and implement educational and information programmes aimed at generating public awareness, with special emphasis on decision-makers in order to ensure support for, and the effectiveness of, disaster reduction programmes.

5.4 Incorporate disaster prevention, mitigation, preparedness and relief in their development plans and ensure implementation of .sustainable development policies.

5.5 Develop sufficiently education and training programmes and facilities for professional staff as well as for the public at large, with a focus on ways and means to reduce disasters.

5.6 Create technical and scientific reference centres throughout the Region.

5.7 Enhance and improve the utilization of NGOs in the mobilization of financial and human resources during disasters.

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TECHNICAL PAPER ON

THE ROLE OF WHO IN EMERGENCIES AND DISASTERS

Summary of recommendations

1. For Member States

1.1 Reaffirm political commitment to reduce national vulnerability to disaster, through the adoption of a clear policy and necessary legislation.

1.2 Where they do not yet exist, develop comprehensive national disaster management plans with emphasis on activities aimed at reducing the potential for and the impact of disasters, and encourage continued mobilization of domestic resources for activities aimed at such reduction.

1.3 Establish a functioning system for the ongoing collection, compilation and dissemination of information relevant to preparedness and response to health emergencies and disasters. It is also essential to strengthen the exchange of information between countries and WHO to allow for speedy response to emergencies and disasters.

1.4 Establish and implement educational and information programmes aimed at generating awareness of the importance of emergency preparedness and response, with special emphasis on decision-makers and the major groups concerned, in order to ensure support for, and the effectiveness of, disaster reduction and preparedness programmes.

1.5 Develop education and training programmes for professional staff as well as for the public at large with a focus on ways and means to reduce the potential for and the impact of disasters.

1.6 Involve nongovernmental organizations which can act as resource mobilizers for funds and expertise in all phases of the disaster continuum.

2. For WHO

2.1 Support national efforts in the field of disaster preparedness and response.

2.2 Identify and support the development of regional collaborating centres in emergencies and disasters management.