3 Response to emergencies

The following brief description of some of the emergency and humanitarian actions undertaken in the different regions reflects the particular needs of the region concerned. No attempt is made to provide an exhaustive list of activities. The intention is rather to trace the main preoccupations and endeavours of WHO at country and regional level during 1996. The WHO regional offices, in particular, have developed strengths in different areas, largely because of the types of disaster or emergency that they most commonly face. Emergency response activities were preponderantly carried out in the African and European Regions, mainly because of the scale and nature of the complex emergencies in those two Regions. Emergency preparedness activities as such are described in chapter 4; in addition, as described below, some of the field support provided by WHO includes an element of training.

African Region

The complex emergencies affecting several countries in the African Region led to huge population movements, putting immense strain on health services already weakened by the effects of years of conflict and unfavourable economic conditions. The health risks to refugees, returnees and internally displaced persons, as well as to indigenous populations, were therefore great. In this context, much attention was focused on the Great Lakes region where conflict situations, massive numbers of displaced persons and transborder refugee flows had grave health implications.

In addition to the emergencies created by conflict or post-conflict situations, the Region suffered from epidemics of cholera, plague, yellow fever, meningitis, Ebola and Lassa fever, and a range of natural disasters, including drought, floods and cyclones. Many countries are facing food emergencies, and the Region comprises a large number of countries classified as "least developed".

The work of EHA in Africa in 1996 exemplifies its proactive approach. In partnership with the Regional Office for Africa (AFRO), EHA was active in the provision of technical and material support to a number of countries facing different emergencies. An EHA regional strategy was formulated for presentation to the forty-seventh meeting of the Regional Committee. The closer relationship and better coordination with EHA at headquarters, and the improving interactions with WHO Representa-

tives at country level have enabled the Regional Office to better respond to the emergency situation in the Region. The severe shortages of financial, material and human resources at the regional level will, however, need to be addressed if the increasing demands of countries of the Region facing emergency situations are to be met. Details of major activities by country are given below.

Great Lakes area

Following an assessment mission, the Director-General of WHO expressed concern about the risk of epidemics. WHO posted a team of experts to carry out surveillance and provide advice, and an emergency health coordinator was appointed. In coordination with other United Nations agencies and under the auspices of DHA, WHO developed an emergency contingency plan for Rwanda, Burundi and eastern Zaire, as well as supporting the health systems of those countries. WHO was able to mobilize about three-quarters of the resources it had programmed to deal with the humanitarian crisis consequent to the massive return of Rwandan refugees in November 1996.

Burundi

The imposition of sanctions brought about a worsening of the health situation in Burundi, which was further exacerbated by the cessation of bilateral assistance and the return of refugees from eastern Zaire. WHO in coordination with other United Nations agencies developed an emergency contingency plan to cope with the evolving crisis. WHO coordinated and supported activities to control meningitis outbreaks in the northeastern provinces (Nyagisozi, Bugera and Ntega), bringing together nongovernmental organizations and national health authorities at central level. The outbreaks were successfully brought under control. WHO helped to strengthen provincial health services by providing drug supplies and human resources (for example, by deploying three surgeons, a gynaecologist and public health United Nations Volunteers). Support to epidemiological training continued, with a focus on the development of an early warning system. Particular attention was paid to the prevention of HIV/AIDS transmission, by helping to ensure safe blood transfusion and the availability of condoms. Technical expertise was provided in the area of epidemiology.

Rwanda

WHO support to the Ministry of Health continued to focus on the rehabilitation of health services, health sector planning, epidemiological surveillance, women victims of violence, safe motherhood and health-care financing. Long-term technical expertise was provided in the areas of epidemiology and public health, and short-term consultants were deployed on request.

The sudden return of nearly 1.2 million Rwandan refugees from eastern Zaire and Tanzania to Rwanda in November and December 1996 posed significant threats to health because it overburdened the capacity of the Government of Rwanda and the international community to provide the necessary care. WHO responded immediately at field level by coordinating health activities and monitoring the health status of the refugees.

WHO assistance included:

- sending epidemiologists, public health specialists, and water and sanitation experts to provide technical support in response to the emergency situation;
- recruiting United Nations Volunteers medical officers to provide medical care in the district health facilities in the communes where there was the greatest influx of refugees;
- making a rapid assessment of the health situation, at the request of the Ministry of Health, following the massive influx of refugees;
- coordinating the activities of national and nongovernmental organizations in districts and communes;
- assisting the Ministry of Health in elaborating the health component of the Government's emergency programme for repatriation and resettlement of returnees;
- providing essential drugs and other medical supplies for the control of cholera and malaria;
- supporting laboratory diagnosis of cholera, including sensitivity testing to drugs.

United Republic of Tanzania

WHO set up a sentinel office in Kigoma to provide health assistance to the massive influx of refugees from neighbouring Burundi, Rwanda and Zaire, as well as to the local population, and to carry out epidemiological surveillance. National and international epidemiologists were recruited, and supplies and logistic support provided. By the end of December 1996, the deadline set by the Government of Tanzania and UNHCR, over 480,000 refugees had returned to Rwanda. A WHO cholera specialist went to Kigoma in December to provide support to control a cholera outbreak.

Zaire

The conflict in eastern Zaire, compounded by the strains caused by the presence for more than two years of 1.25 million Rwandan and Burundian refugees, sparked the mass movement of most of these refugees in November and December 1996, creating 250,000 internally displaced persons and affecting at least 500,000 others inside the coun-

try. Most of the people within these groups were dependent for their survival on urgent emergency assistance. As part of a contingency plan, WHO set up several epidemiological sentinel stations, in particular in Goma, Bukavu and Kisangani.

Other major areas of activity

Angola

Using the approach of "health as a bridge for peace", WHO worked with the Government and with UNITA, bringing both sides together to deal with health matters and thereby helping to construct a climate of confidence. WHO assisted the Angolan Government in policy planning and management of health services at provincial level, in collaboration with nongovernmental organizations. An emergency health coordinator was seconded to the United Nations Humanitarian Assistance Coordination Unit to oversee health activities for demobilized soldiers. WHO continued to coordinate health services for demobilized soldiers and their families in these areas, and provided direct assistance for trypanosomiasis control in quartering areas through the provision of medicines and laboratory supplies. In collaboration with nongovernmental organizations, WHO conducted epidemic assessment and training, and provided vaccines to control outbreaks of meningitis. Health coordination and support were provided to provincial health authorities by WHO and United Nations Volunteers and health situation assessment missions were conducted in the provinces of Kuanza Norte, Malange and Zaire. WHO brought together the Government and UNITA when necessary in order to take specific action to control epidemic disease outbreaks. Technical expertise was provided in the areas of health policy and health emergency coordination, at central and provincial level.

Eritrea

The rehabilitation of three institutions for training nurses, health assistants and midwives was completed and teaching/learning materials were developed. The WHO programme also helped to construct and equip orthopaedic centres to meet the needs of war victims, as well as providing training for national staff. WHO continued to provide fellowships and equipment to the Department of Pharmacy of the Ministry of Health. In collaboration with the University of Messina, Italy, WHO provided surgical equipment and expertise to the central hospital in Asmara. A series of workshops on nutrition management in emergencies was conducted in conjunction with UNHCR.

Liberia

WHO provided medical supplies, including cholera control material, emergency kits, and medicine for leprosy patients who had been abandoned during the civil unrest. WHO coordinated activities to control

yellow fever outbreaks, and supported the training of vaccinators, as well as national teams in the field. More than 1.3 million people were vaccinated against the disease. The situation in Liberia worsened in April 1996, however, when fighting resumed and the health system again collapsed in Monrovia. EHA, in collaboration with the Regional Office for Africa, supplied surgical and medical kits. Logistics (including communications equipment and computers) were provided to re-establish the operation of the WHO Representative office, and a public health specialist and a logistician were appointed to strengthen the WHO team.

Following an agreement in August 1996 between the parties to the conflict, and despite cease-fire violations which prevented humanitarian relief reaching thousands of people in the South-Eastern and Cape Mount counties, the situation improved towards the end of the year. In collaboration with other partners, WHO was able to contain outbreaks of cholera and provide support to water and sanitation activities.

The civil war resulted in the displacement of some 1.5 million people, while the end of hostilities and the beginning of demobilization led to further population movements. Medical units at demobilization sites, staffed by the Ministry of Health (with incentives being paid to doctors by WHO), were the only sources of primary health care services to people long cut off by war. Encouraged by the presence of demobilization sites, as well as visits of the humanitarian community to remote areas, refugees and displaced persons started returning home. Epidemiological surveillance was strengthened to ensure the early detection of epidemics.

Sierra Leone

WHO supported the development of an early warning system for outbreaks of epidemics; provided financial and material support for training in the prevention and care of diarrhoeal diseases and acute respiratory infections; and helped to support and coordinate disease control activities following outbreaks of cholera, yellow fever and Lassa fever. In collaboration with other organizations of the United Nations system and nongovernmental organizations, WHO supported the rehabilitation of the health system.

Following the restoration of a multi-party democracy in March 1996 and the ensuing cease-fire agreement, relief assistance remained focused on internally displaced persons and others affected by war. In order to facilitate post-war recovery, the Government of Sierra Leone proposed a national resettlement, rehabilitation and reconstruction programme with two basic components:

- a quick action programme (QUAP) designed to address urgent short-term needs of resettlement and rehabilitation over an estimated period of two years;

- a three-year medium-term reconstruction programme, designed to lay the foundation for long-term growth and development.

The Ministry of Health and Sanitation, with the assistance of WHO, UNICEF and nongovernmental organizations, made significant progress in addressing the problems caused by overtaxed health services and other social amenities. Satellite health clinics were established near camp populations throughout the country. Child immunization continued in all accessible areas, and coverage in the western area increased from 43% to 70%. Nutritional status stabilized, and the creation of a water and sanitation technical committee together with a cholera subcommittee was instrumental in enhancing the national cholera preparedness and response capacity.

Response to other emergencies

In collaboration with the WHO Division of Emerging and Other Communicable Diseases, EHA supported the Regional Office for Africa in disease control activities in various countries, such as the Ebola fever outbreak in *Gabon*, and meningitis outbreaks in *Benin, Burkina Faso, Chad, Nigeria, Niger* and *Mali*. WHO also gave support to the *Central African Republic* during a military rebellion that affected the health of the civilian population. In addition, WHO supported the health systems of *Côte d'Ivoire* and *Guinea*, which had been put under pressure by the influx of refugees. Emergency medical supplies were provided to flood victims in *Ethiopia*. In *Mozambique*, the programme for the rehabilitation of health services was completed, and WHO, with support from the Government of Japan and in collaboration with the Association of Medical Doctors for Asia, provided technical and logistical backing, essential drugs and other medical supplies to control the increase in malaria and diarrhoeal diseases, resulting from the heavy flooding in Gaza province.

Region of the Americas

In addition to the political tensions, the Region of the Americas was affected by various natural disasters, including hurricanes, an earthquake and floods. Although each of these disasters attracted some funding, the overall response of the international community continued to be slow and small in all sectors, in a climate of fiscal austerity and "humanitarian fatigue".

The lack of international response was, however, largely compensated for by the high level of national preparedness capacity and, as in previous years, great emphasis was placed on strengthening even further the capability of the Region and of individual countries to prepare for emergencies and to mitigate the health consequences of disasters. These activities are reported in chapter 4.

Response to emergencies

AMRO/PAHO was responsible for the direct management of more than US$ 1 million in relief funds, including grants for emergency environmental problems. In particular, AMRO/PAHO responded to floods in *Cuba, Honduras* and *Guyana*, and an earthquake in *Peru*.

Eastern Mediterranean Region

As well as conflict situations, the Eastern Mediterranean Region faced natural disasters, including floods and earthquake damage. The main relief and rehabilitation activities carried out during 1996 are outlined below.

Afghanistan

In view of the grave situation in Afghanistan, WHO technical and material assistance focused on three priority areas identified in conjunction with the public health authorities.

- strengthening and establishment of emergency medical and casualty units in all regional and provincial hospitals to cope with landmine and war injuries, as well as other casualties,
- disease prevention and control;
- human resources development.

Implementation of a health emergency relief programme was continued throughout 1996 to provide emergency health assistance to the local communities and the displaced population

Activities related to disease control, the provision of essential drugs, and the upgrading of hospitals and health services were directed and financed in coordination with a range of partners, including UNOCHA, UNHCR and WFP. In particular, WHO undertook the physical and functional rehabilitation of a number of health institutions, hospitals and health centres in different regions of Afghanistan. This involved the reconstruction or renovation of premises and the provision of medical and laboratory equipment and supplies, and health care documentation. An orthopaedic operating block was rehabilitated and a wheelchair production unit was established in conjunction with Handicap International

The water supply system in Faizabad, Jalalabad and Kandahar was rehabilitated in collaboration with other United Nations agencies and nongovernmental organizations. Public health staff were trained on the interrelationship between water, sanitation and health, water surveillance and cholera prevention. Around 285,000 people are benefiting from these projects.

An integrated community-based development programme was introduced in the eastern region of Afghanistan, under the basic devel-

opment needs (BDN) approach. Training materials and a questionnaire for conducting rapid socio-economic surveys were developed for the programme, and an intersectoral technical support team was set up to assist communities in their endeavours to improve their lives through sustainable social services, including health.

As part of its advocacy role, WHO negotiated with the Taliban forces controlling most of Afghanistan to allow women to take part in the health education and in work activities offered by various WHO programmes. WHO succeeded in negotiating the passage of relief convoys through the military front to besieged Kabul in winter 1996.

The mass immunization campaign, carried out by WHO and UNICEF in conjunction with the Ministry of Health and nongovernmental organizations, was another example of WHO efforts both to control communicable diseases and to implement the objective of health as a bridge for peace. Through advocating the right of all Afghans to health, negotiating a humanitarian cease-fire, providing training and promoting extensive nation-wide social mobilization, WHO demonstrated its capacity to confirm the primacy of health and humanitarian issues above the military conflict.

Iraq

WHO continued its efforts to put health issues, particularly the detrimental impact of sanctions on the health and welfare of vulnerable populations, high on the humanitarian agenda, in particular through monthly reports and contacts with donors, the media and other concerned agencies.

Security Council Resolution 986 allows the sale of oil for the purchase of medicines and food. In its role as observer and implementer of Resolution 986 with respect to drugs and medical equipment, WHO was engaged in the preparation of the distribution and observation plans required under the Memorandum of Understanding signed between the United Nations Secretariat and the Iraqi Government. With regard to new medical equipment and spare parts in the distribution plan, the WHO Representative in Iraq visited hospitals in the north, developed revised formats, and assigned an expert engineer to review all details related to spare parts and the identification of new equipment. WHO also made efforts to improve the drug distribution and management system, including the rational use of drugs. Work started on the revision of lists of drugs at different levels of the health care system and in implementing a country-wide programme of training seminars on the rational use of drugs.

On the basis of several health situation assessments, WHO collaborative activities with Iraq, funded from the regular budget, focused in particular on the serious problem of lack of essential emergency drugs and other medical supplies.

Palestinian Self-Rule Areas

WHO supported institutional development and infrastructure-building in the Palestinian Self-Rule Areas as a contribution to the peace process. Within the coordinating mechanisms established by the Office of the Special Coordinator in the Occupied territories (UNSCO), WHO continued to act as secretariat to the health sector group. In addition to its coordinating role, WHO provided technical and material assistance to the Palestinian Ministry of Health. Advice was given on the functioning of the future central public health laboratory being built by Italy. A team of nursing and health training experts worked with Birzeit University to establish the first diploma course in primary health care. Another technical contribution was the establishment of a plan to formulate a list of essential drugs and a drug quality assurance policy. WHO and UNDP, together with the European Commission, worked with the Ministries of Health and Agriculture on the development of a programme on zoonozic disease control policy.

A WHO team looked into the existing expanded programme of immunization against preventable diseases and formulated recommendations on improving surveillance, which have been incorporated into the public health programme of the Ministry of Health.

Somalia

Despite deteriorating security conditions, especially in Mogadishu, WHO staff kept working to improve the health of the population. All WHO activities were geared towards alleviating the health consequences of the disintegration of governmental institutions. WHO supported disease control activities focusing on diarrhoeal diseases, acute respiratory infections, malaria, sexually transmitted diseases and tuberculosis. A simplified disease surveillance system was developed and the essential drugs programme was further decentralized. WHO supported the development of laboratories by providing materials, technical guidelines and training, as well as carrying out repairs.

WHO distributed essential drugs to selected national and international nongovernmental organizations, and area health authorities and facilities. In response to outbreaks of cholera, WHO provided medical supplies and health education materials, as well as training for Somali professionals in the prevention, control and treatment of cholera. More than 600 professionals benefited from WHO in-country training programmes, and 16 Somali nationals attended training courses outside the country. In preparation for a possible nutrition crisis, 20 Somali health professionals were trained as trainers in nutrition assessment in emergencies and the operation of therapeutic feeding centres. Under war conditions, and lacking resources to implement the primary health care strategy, WHO continued to pursue the basic minimum needs approach as a basis for development and to sustain the community health system. WHO provided support for 52 villages applying the approach in the Merca region in south Somalia.

Sudan

The life-threatening diseases affecting populations living in areas of conflict in the southern part of the country were the focus of WHO activities in Sudan, and efforts were made to increase WHO's participation in Operation Lifeline Sudan. WHO, as executing agency of a UNDP-funded project, continued to work towards strengthening the capacity of the Ministry of Health in emergency preparedness and response. WHO achievements include:

- creation of a surveillance system able to produce hazard mapping and risk analysis;
- creation of a radio network (over 50 sets) linking Khartoum with 17 states;
- creation of an early warning system for emergencies;
- improvement of the capacity of nationals for timely response to emergencies;
- strengthening of coordination and linkage between concerned ministries and with other agencies;
- production of a manual on emergency preparedness and response for health workers and nongovernmental organizations;
- establishment of emergency management committees at different levels.

Under the project, a national workshop was held on the integration of emergency and humanitarian activities into the primary health care system. Emergency and humanitarian activities were institutionalized by linking them with existing training centres and institutions. A start was made on developing guidelines for hospital contingency plans, and the training guidelines on emergency and humanitarian action were upgraded. Training was provided for state-level focal points, radio operators and radio technicians.

Health problems, in particular malaria, diarrhoeal diseases and eye infections, started to increase following the heavy rainfalls during August 1996, which led to wide areas being covered by water and rapidly moving streams flowing into the Nile. Essential medical supplies and insecticides were provided.

Yemen

In the aftermath of the flooding in June 1996, the risk of outbreaks of diarrhoeal and other water-borne diseases increased and the seasonal transmission of malaria was expected to increase sharply. A rapid assessment was made of the situation, and anti-malaria drugs, supplies for the control of diarrhoeal diseases, as well as essential drugs were provided. All donations of medicines and other medical supplies were channelled through WHO and distributed according to the real needs of the affected areas.

European Region

Following the disintegration of the former USSR, several newly independent countries became members of the European Region. These newly independent States are undergoing enormous economic and social, as well as political, changes which are adding to the burden of ensuring a social safety net for vulnerable groups. In addition, the large numbers of displaced persons constitute an additional risk factor and place an added demand on the already overstretched public sector. The environment of social and political unrest has repercussions on the health sector in terms of disease and health status trends.

The role of humanitarian assistance in the reform process in the newly independent States was examined by a workshop organized by the Regional Office for Europe in November 1996. One of the key questions raised was how to link emergency health assistance with long-term capacity building. The health situation in the countries of central and eastern Europe, as well as in the newly independent States, is deteriorating. There is a lack of knowhow, funding and management capability. In such an environment, it is important that urgent humanitarian aid should support rather than undermine health sector development. The major activities carried out in the European Region during 1996 are mentioned below. Countries are grouped by focus of activities, rather than being listed alphabetically.

Albania

Following an outbreak of poliomyelitis which started in April 1996, WHO and UNICEF jointly launched an appeal to support the control of this epidemic and prevent its spread into the surrounding areas. The response to this appeal was swift and led to the organization of a mass immunization campaign, the treatment and rehabilitation of those affected and the implementation of action plans to prevent the spread of the disease into the bordering countries. Virtually the entire population was covered in two rounds of immunization.

Bosnia and Herzegovina, Croatia, Federal Republic of Yugoslavia

WHO continued to operate an emergency and humanitarian programme (initiated in 1992), within the overall United Nations programme. In June 1996, in line with other United Nations agencies, the main focus of the coordination of humanitarian assistance was transferred to Sarajevo. The need for humanitarian health assistance did not dissipate with the signing of the Dayton agreements, and WHO actively identified and addressed urgent health needs wherever possible. Throughout the year, however, emphasis moved increasingly towards health reform and reconstruction.

The network of WHO area and field offices was expanded, to ensure a

non-partisan representation. Field offices were opened in Bihac, Banja Luka and Pale (Bosnia and Herzegovina) and in Vukovar/Erdut (eastern Slavonia, Croatia). This field presence made it possible to have a comprehensive overview of health, and allowed for the coordination of the health sector at regional and national levels. It also made possible the rapid identification of and response to threats to health.

The proliferation of international agencies operating in the mission area, particularly in Bosnia and Herzegovina, intensified the need for coordination and intersectoral collaboration. Reconstruction projects, for example housing for returning refugees, cannot be successful without complementary health, education and employment opportunities. WHO, as the lead health agency, coordinated health activities to ensure that priority needs were identified and met, and that the health sector worked synergistically with other sectors.

The coordination of an adequate emergency response continued, but the provision of emergency medical supplies was generally scaled down and the logistics capacity was reduced to a minimum. WHO continued to build up national professional capacity to provide appropriate services, especially to vulnerable groups. Needs assessments included comprehensive surveys of the location and condition of health care facilities in relation to displaced persons and repatriation. The number and pattern of returnees did not, however, follow expected trends, and population movements are anticipated during 1997, as changes in refugee status occur in countries where asylum was sought.

Among public health interventions were the continued monitoring of health standards, water quality and nutrition, in support of needs assessments. Extensive and detailed epidemiological studies were made, providing data which had been impossible to collect in recent years. This information was invaluable to the ministries of health at cantonal and central level, in terms of planning reconstruction and reform within the health care system. A legacy of the uncoordinated aid early in the conflict was the stockpiles of expired drugs and other medical supplies. Whilst addressing the general lack of disposal of solid waste, advising on the destruction of these items was undertaken by WHO as part of an overall strategy to secure sanitation standards and avert public health crises.

Following an outbreak of poliomyelitis in Albania, and its subsequent spread to Greece and Kosovo (Serbia and Montenegro), it was decided that preventive measures were needed, in addition to the continuing epidemiological surveillance and information campaigns, given the low immunization rates during the war. WHO and other humanitarian organizations assisted the health authorities in the Federal Republic of Yugoslavia (Serbia and Montenegro) in implementing sub-national polio immunization days. These concentrated on Kosovo, adjacent municipalities and others selected as having risk potential in central Serbia. Two rounds of immunizations of children under five years of

age took place, in September and November 1996, achieving 98% and 97% coverage, respectively. The target group was subsequently extended to children under 15 years of age in Kosovo. In Bosnia and Herzegovina, two national immunization days were held in December 1996. The target group was children under six years of age, and 137 municipalities participated. Over 600 immunization points were opened and manned by health authorities, with technical support from UNICEF, International Medical Corps and nongovernmental organizations, and logistical support from IFOR. These emergency activities will make a lasting impact on future health in the countries concerned.

The programme of rehabilitation of war victims continued to focus on needs for physical and psychosocial assistance. As well as building the capacity of health professionals, ministries of health were urged to plan reforms for the future care of vulnerable groups through a community-based approach, closely linked to primary health care.

During the war, mental health assistance focused on war trauma treatment and counselling services mainly targeting women and children. In the post-war period, "coping" is superseded by facing the realities of the aftermath of the conflict. Traumatization of families and subsequent psychosocial vulnerability still need to be addressed. Large numbers of demobilized soldiers and war invalids have faced post-trauma related symptoms. Further training of professionals, and promoting understanding and social acceptance of mental problems is necessary.

A review of needs and services for people with mental retardation was carried out in 1996. During the conflict, this group suffered a double handicap by being given little priority for scarce resources. WHO raised awareness of this and other vulnerable groups, including the elderly, in order to ensure that the future health care system develops in line with current ethical standards.

The elderly and children are the first indirect victims of war. Few data exist on the impact on them of uprooting and displacement. In post-conflict Bosnia and Herzegovina, WHO continued to draw attention to the needs of these groups. A survey was carried out in February and March 1996 on the health and social situation of elderly people in Sarajevo. In the light of its results, WHO emphasized the need to develop new community-based services for the elderly, in which health, social and welfare services are synchronized to produce relevant care.

WHO continued to bring together representatives of medical associations, throughout the hostilities, to maintain a dialogue and re-emphasize that health issues are of common interest, and supported ministries of health in planning and managing the process of reconstruction and reform. In September 1996, the Ministers of Health of Bosnia and Herzegovina signed a joint statement to the international community, an unprecedented step that sent a positive message to health professionals and their communities. Frameworks of health care systems were outlined within strategic health plans for both entities (Federation and

Republika Srpska). Needs assessments provided a conceptual background for programmes on primary health care and public health, and pilot projects are planned. In addition, WHO convened and supported working groups on public health, pharmaceuticals, and health information management

In eastern Slavonia (Croatia), within the framework established by the United Nations Transitional Administration (UNTAES), WHO worked to build confidence between Croatian and Serbian health professionals with the aim of implementing joint health activities, integrating eastern Slavonian and Croatian health staff into the Croatian health care system, and incorporating the population of eastern Slavonia into the Croatian health insurance system. Distrust on the part of patients and obstruction or intimidation by officials and individuals have led to unwillingness to accept services from other ethnic groups. UNHCR requested WHO to assist in the development of strategies to address these issues. Lessons are being drawn from five years of experience for the guidance of WHO action in similar complex emergencies in the future.

WITH FUNDS DONATED by the European Community Humanitarian Office of the European Union , WHO was able to contract the International Centre for Migration and Health, Geneva, Switzerland, a WHO collaborating centre for health-related issues among people displaced by disasters, to assess the health of displaced people in Bosnia and Herzegovina. The survey included over 1,400 families, covering more than 5,200 individuals, and produced information allowing for an assessment of the health status and projected health care needs of internally displaced persons and refugees, the state of existing health care facilities notably in areas earmarked to receive resettled people, the drug supply situation, and the resettlement potential of the displaced populations.

Armenia

A water and sanitation project, which included training courses for professionals on the epidemiological aspects of outbreak investigation, drinking water surveillance and engineering aspects of water management, was completed. Chlorine disinfection plants were installed for demonstration purposes in connection with the latter course. Leakage detection equipment and various handbooks in Russian and Armenian were supplied.

Various kits (diphtheria, tuberculosis, epidemic response and laboratory), medical supplies and equipment were delivered for distribution in January 1997, and the tuberculosis control programme continued. A programme to improve the primary health care of women living in suburban Yerevan is under way to provide modern equipment for a prenatal facility, upgrade the knowledge and skills of health personnel, set up a referral system, and develop guidelines for prenatal assistance

A plan of action on health information and policy development was prepared and presented to the Minister of Health.

Azerbaijan

A plan was prepared for the development of health information services, focusing on improving data generation, analysis and use for managing health services in the districts implementing health care reform.

The tuberculosis control programme continued satisfactorily in three pilot areas. Diphtheria kits were provided to help in the control and diagnosis of diphtheria. Malaria remains a persistent problem. A health and nutrition survey, carried out in April 1996, found evidence of chronic malnutrition, but no signs of acute malnutrition. A proposal for a project on anaemia and health was prepared.

Georgia

Three courses for water and sanitation professionals were held. Chlorine disinfection plants, leakage detection equipment and information documents in Russian and Georgian were provided.

A working group on clinical diagnostics, treatment and the recording of performance was held in Tbilisi, in which teams from each of the Caucasus countries advised on specific health problems and service activities. A national tuberculosis control programme was put in place by the Ministry of Health in 1995, which by 1997 will cover the whole country. Although case notification is still relatively high, there was a decline during the third quarter of 1996 (475 new cases were detected in the pilot areas compared with 963 in the previous quarter). Local staff are being given in-service training, and close supervision will continue into 1997.

Russian Federation

In response to the humanitarian crisis in the Chechen and surrounding republics in the north Caucasus, WHO together with partners in the United Nations system and national authorities provided supplies for the treatment and diagnosis of tuberculosis, immunization, laboratories and sanitation for the thousands of internally displaced persons. In addition, workshops were conducted and guidelines provided on the control and prevention of diarrhoeal diseases including cholera, on tuberculosis treatment, and on mental health services.

Work commenced on the first phase of a three-phase mental health rehabilitation programme to provide local mental health professionals, community-level health workers and staff of international health relief agencies with up to date information on the identification, treatment, care and rehabilitation of persons with mental and psychological traumatic stress disorders.

Some 150 amputees were fitted with artificial limbs before the prostheses workshop, established in Nazran, Ingushetia, in September 1996, closed in December because of lack of funds.

Tajikistan

WHO technical advisers assessed the malaria and typhoid fever epidemics. A Tajikistan Donor Alert on the urgent humanitarian needs in the country was launched by DHA in December 1996, containing WHO proposals for programmes for the containment of both epidemics. These programmes will strengthen, on an emergency basis, the epidemic control capacities of the health service by providing adequate drugs, and laboratory equipment and supplies, training health professionals in disease management, improving control and surveillance procedures, and improving the water and sanitation situation.

South-East Asia Region

The South-East Asia Region, which includes several disaster-prone countries, faced both natural disasters and complex emergencies during 1996. Besides responding to specific emergencies, WHO made a special effort to strengthen national capacity to prepare for emergencies, as reported in chapter 4.

Democratic People's Republic of Korea

WHO assessed the impact of floods on the health care delivery system and mobilized extrabudgetary funds for flood relief. In addition, approximately US$ 1 million of WHO's regular budget was used to supply urgently needed essential drugs, vitamins and medical supplies.

Sri Lanka

WHO raised extrabudgetary funds for humanitarian action in favour of the population affected by civil conflict and took action, in collaboration with the United Nations Emergency Task Force, in:

- improving the flow of medical supplies to the affected population by standardizing medical supplies, facilitating dialogue among the bodies concerned, and setting up an emergency supplies management system;
- training staff of nongovernmental organizations involved in providing assistance.

Other support

WHO technical support was provided in the area of emergency and disaster management to *Indonesia* and *Nepal*. WHO also provided funds to meet the need for medical supplies of the population affected by

floods in *Nepal*. In *Myanmar*, with funding from UNHCR and in collaboration with the Ministry of Health and UNHCR, WHO helped to reinforce health services for returnees from Bangladesh in Rakhine state by implementing a health education and training project

Western Pacific Region

WHO emergency and humanitarian activities in the Western Pacific Region during 1996 focused on training in the areas of disaster management and preparedness, and on responding to the natural disasters that affected countries of the Region. The emergency preparedness activities are reported in chapter 4. WHO provided some small financial assistance for emergency relief medical supplies to countries in the aftermath of the disasters. The main activities are mentioned below.

In *China*, following the earthquake in Yunan Province, WHO implemented the purchase of emergency supplies with funds from the Government of Italy. In the *Lao People's Democratic Republic*, after the floods in the southern and central provinces, the Government of Australia donated funds to WHO for immunization to control the diphtheria outbreak. WHO provided technical and financial support for a training course and the formulation of plans for diphtheria and tetanus immunization campaigns at provincial and district levels. In *Viet Nam*, because of the severe typhoon damage to several provinces, the Government of Italy pledged funding for emergency immunization and public health programmes.