Annex 1

THE MANDATE OF WHO IN HUMANITARIAN RELIEF OPERATIONS

WHO has a constitutional obligation to furnish appropriate technical assistance in emergencies and to provide necessary aid upon the request or acceptance of governments (WHO Constitution, Chapter II, Article 2(d)). It is also a statutory obligation of the Executive Board to take emergency measures within the functions and financial resources of the Organization to deal with events requiring immediate action. The Board may authorize the Director-General to take the necessary steps to participate in the organization of health relief to victims of a calamity, the urgency of which has been drawn to the attention of the Board by the Director-General (WHO Constitution, Chapter VI, Article 28 (i)).

The general and country-specific strategies of WHO in emergencies derive from resolutions of the United Nations General Assembly. Annex 1 of resolution 46/182, on strengthening the coordination of humanitarian emergency assistance of the United Nations, describes a set of guiding principles. *Inter alia*, this resolution requests the governing bodies of organizations and entities of the UN system to examine reserves and other contingency funding arrangements to strengthen their operational capacity for rapid and coordinated response. WHO also is party to the International Framework of Action for the International Decade for Natural Disaster Reduction (see UN GA resolution 44/236).

WHO actions are, of course, in accordance with the policies of the Organization's own governing bodies. WHO's responsibility for the health aspects of humanitarian assistance is restated in a resolution (WHA46.6), emanating from the Forty-sixth World Health Assembly, which called for a strengthening of regional mechanisms for efficient health management in emergencies. Specific guidance is contained in a document (EB91/2) submitted to the ninety-first session of the Executive Board, which reviews WHO's accomplishments in emergency relief operations, together with the related mandate and objectives. A resolution (EB91.R10) called on the Director-General to report to the ninety-third session of the Board on:

- the resources that the Director-General proposes to allocate for these activities under the 1994–1995 programme budget;
- the extrabudgetary support obtained during the reporting period and the activities undertaken with this support; and
- cooperation within the UN system, and with other international organizations, in situations requiring humanitarian assistance.

The regional mandate in Europe derives from a 1983 resolution of the WHO Regional Committee for Europe (EUR/RC33/R5). Country-specific activities of the Organization, for example in the former Yugoslavia, are defined by resolution EUR/RC42/R7.

Annex 2

LIST OF DONORS

Australia

Canada

Commission of the European Communities (CEC)
European Community Humanitarian Office (ECHO)

City of Berlin

Denmark

Finland

France

Germany

Ireland

Italy

Japan

Netherlands

Norway

Queen's University, Ontario, Canada

Sweden

Switzerland

United Kingdom

United States of America

UNHCR

To the above must be added miscellaneous donations in cash and in kind.

Annex 3

LIST OF PERSONS MET BY THE WHO EXTERNAL EVALUATION TEAM DURING THE PERIOD 7–17 JUNE 1994

BELGRADE

AGENCY	NAME	JOB TITLE/DEPARTMENT
BELGRADE WATER WORKS AND SEWERAGE	TAUSANOVIC, Mr Vladimir	Director
ECHO	CORNELIS, Ms Muriel FORMENTI, Mr Jose Luis Vinuesa	Coordinator Chief of Mission
INSTITUTE OF MENTAL HEALTH	KALICNAN, Dr Predrag SPANOVIC, Dr Veronica	 Head, Research Department
INSTITUTE OF ORTHOPAEDIC PROSTHESIS (RUDO)	VRANIC, Mr Krsta JOVANOVIC, Mr Ljubisa	Director Head of Application Services
INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES	SEPELLA, Mr George TOPPILA, Dr Lisa	Deputy Head of Delegation Medical Coordinator
INTERNATIONAL RESCUE COMMITTEE	MONTELL, Mr Leland	Head of Mission
MEDECINS SANS FRONTIERES	DIAP, Dr Graciela STOBBAERTS, Mr Eric	Medical Coordinator Chief of Mission
MINISTRY OF HEALTH	PESIC, Dr Miomir POPOVIC, Mr Velibor STOJANOVIC, Dr Ljiljana TANJEVIC, Mr Budimir ZIVULJ, Mr Zoran	Deputy Minister Minister Deputy Minister Chief of Cabinet Senior Adviser
TRANSFUSION INSTITUTE OF SERBIA	MEDIC, Dr Petar PETROVIC, Dr Oliver	Plasma Department Health Assistant

UNICEF	POPOVIC, Dr Dragoslav	Assistant Project Officer
UNHCR	HAGENAUER, Mr Joe	Programme Officer
	GARLOCK, Mr Rick	Deputy Chief of Mission
UNIVERSITY CLINICAL CENTRE OF SERBIA	ANTUNOVIC, Dr Vasa	Medical Director
	BOGUNOVIC, Dr Nikola	Social Medicine Department
	DJORDJEVIC, Dr Zivorad	Director
	MITROVIC, De Meko	Director of Emergency Surgery
WHO	ALEXSANDAR, Mr Kisic	Supply Clerk
	BJELAJAC, Mr Stevan	Supply Clerk
	MARGITIC, Ms Tamara	Administrative Assistant
	PUKKILA, Dr Jukka	Acting Special Representative
	SEKULOVIC, Mr Radisa	Receptionist/Clerk
	TASIC, Dr Nebojsa	Epidemiologist
	VISNJIC, Mr Cedomil	Database Manager
	VOJNOVIC, Ms Marina	Clerk/Typist

COPENHAGEN

AGENCY	NAME	JOB TITLE/DEPARTMENT
WHO	ASVALL, Dr Jo E.	Regional Director
	BLACK, Dr Mary E.	Short-term Professional, COR
	BONNEFOY, Mr Xavier	Regional Adviser, Health Planning/Ecology
	DANZON, Dr Marc	Director, Country Health Development
	FARIA, Dr Jose E.	Regional Adviser, Mental Health
	FUTRILLE, Ms Jane	Legal Officer
	HELSING, Dr Elisabet	Regional Adviser, Nutrition
	KRISTENSEN, Ms Eliane	Technical Assistant, COR
	LARSEN, Mr. Helge	Management Development
	LARUSDOTTIR, Dr Johanna	Head, WHO Office, Split (visiting)
	LEUS, Dr Xavier	Regional Adviser, COR
	MACFADYEN, Dr David	Director, Programme Management
	MURPHY, Ms Carolyn	Director, Administrative Support
	NOLAN, Mr David	Personnel Manager
	OFFERHAUS, Dr Leo	Acting Regional Adviser, Pharmaceuticals

SARAJEVO

AGENCY	NAME	JOB TITLE/DEPARTMENT
CATHOLIC RELIEF SERVICES	MIRKOVIC, Mr Sasa	Programme Officer
KASINDOL HOSPITAL	MIJATOVIC, Mr Srdjan	Trainee Surgeon
KOSEVO HOSPITAL	CERIC, Dr Ismet	Director of Mental Health
	KONJHODZIC, Dr Faruk	Director
	MUJIC, Dr Muzafer	Director of Rehabilitation
MINISTRY OF HEALTH	BEGANOVIC, Dr Mustafa	Minister of Health
	HASIC, Ms Jasna	Deputy Minister of Health
	LUCIC, Mr Slobodan	Adviser on Pharmacology
MEDECINS SANS FRONTIERES	BRUENS, Ms Go	Logistics Coordinator
	MASLESA, Dr Ljiljana	Medical Programmes Officer
	SARDAREVIC, Dr Dzelal	Medical Programmes Officer
PRIMARY HEALTH CARE CENTRE	TOKIC, Dr Mahir	Director of Health Centres, Sarajevo
PSYCHIATRIC CLINIC, KOSEVO	CERIC, Professor Ismet	MoH Coordinator for Mental Health
	DANCEVIC, Dr Milka	Junior Psychiatrist, Assistant to the MoH Coordinator for Mental Rehabilitation
	MUJIC, Dr Muzafer	MoH Coordinator for Mental Health
PUBLIC HEALTH INSTITUTE	SMAJKIC, Professor Arif	Director, and Minister for Refugees, Labour and Social Welfare
	PUVACIC, Dr Zlatko	Head Epidemiologist
	MASLESA, Ljiljana	Medical Adviser

REGIONAL PUBLIC HEALTH SERVICES	SEHOVAC, Dr Jovan	Director
SARAJEVO UNIVERSITY CLINIC	KONJHODZIC, Dr Faruk	Director, and President of the Medical Association of Bosnia and Herzegovina
STATE HOSPITAL	NAKAS, Dr Bakir	Director
UNICEF	BARBIERI, Ms Giovanna	Head of Office
UNHCR	DECK, Mr Peter KESSLER, Mr Peter RIDJANOVIC, Ms Lejla	Acting Head of Office UNHCR Spokesman Programme Assistant
UNPROFOR	MIHOV, Mr Deyan	Senior Civil Affairs Officer
WHO	MILADINOVIC, Dr Ksenija SIMMONDS, Ms Stephanie TERVAHAUTA, Dr Risto	Health Information Centre Coordination Special Representative for Bosnia-Herzegovina Head, WHO Office

TUZLA

AGENCY	NAME	JOB TITLE/DEPARTMENT
CENTRAL HOSPITAL	MISIC, Dr PH Katica VOJISLAV, Mr Stankovic	Head of Pharmacy Head of Maintenance Service
ICRC	AKANI, Ms Luisa	Field Nurse
IRC	HADZIHASANOVIC, Mrs Meliha	Field Assistant
INTERNAL CLINIC	SMAJIC, Dr Abdulah	Head of Clinic
MEDECINS SANS FRONTIERES	CONK, Mr William	Logistician

PROSTHESIS WORKSHOP	KAPIDZIC, Dr Suada PRETE, Mr Roger	Head of Workshop Head Technician, representing "Handicap International"
REGIONAL HOSPITAL OF TUZLA	HADZIEFENDIC, Dr Hilmija	Deputy Director
TUZLA EMERGENCY CENTRE	PAVLOVIC, Dr Dusan	Head of Centre
TUZLA HEALTH CENTRE	GILDING, Dr Stanimir	Director
UNICEF	WALSH, Mr Erin	Head of Office
UNHCR	KHAN, Mr Hassan	Programme Officer
WHO	AZABAGIC, Dr Almir HUREMOVIC, Ms Lejla NADZAKOVIC, Mr Faruk PERKOVIC, Ms Verna RUBIN, Dr Margareta	Assistant Secretary Driver/Warehouse Keeper Specialist in Social Medicine Head of Field Office

ZAGREB

AGENCY	NAME	JOB TITLE/DEPARTMENT
	HENIGSBERG, Dr Neven	Adviser to the Vice President of Croatia
ICRC	MARCUS, Mr Michael	Medical Coordinator
ECTF	SHEPHERD-BARON, Mr James	Medical Coordinator
IFRC	MANLEY, Mr John UZICANIN, Dr Amra	Deputy Head of Delegation Medical Adviser
OFFICE OF FOREIGN DISASTER ASSISTANCE/US DISASTER ASSISTANCE RESPONSE TEAM	McGIBBON, Mr Evan	Grants Officer
MEDECINS SANS FRONTIERES	CURRY, Ms Leanne	Medical Coordinator

UNHCR	ABU-ZAYD, Ms Karen	Chief of Mission for Bosnia-Herzegovina
	MORRIS, Mr Nicholas	Special Envoy
UNICEF	FAROOQ, Mr Shamsul	Senior Programme Officer
	McDERMOTT, Thomas	Special Envoy
USAID	YATES, Mr Tom	Programme Officer
WFP	JONES, Mr Michael	Deputy Director of Operations
	MORTON, Mr David	Director of Operations
WHO (Area Office)	van ALPHEN, Dr Dana	Field Officer
	JAGANJAC, Dr Nermina	Nutrition Adviser
	JENSEN, Dr Soren	Mental Health Consultant
	LOUIS, Mr Didier	Public Health Engineer Consultant
	MILLER, Mr James	Budget and Finance Officer (EURO)
	TODD, Mr Anthony	ODA Logistics Officer
	VUORI, Dr Hannu	Special Representative
	WATSON, Ms Fiona	Nutritionist

ZENICA

AGENCY	NAME	JOB TITLE/DEPARTMENT
MINISTRY OF HEALTH, BOSNIA AND HERZEGOVINA	SMILBEGOVIC, Dr Abdullah	Representative, liaison to UN/NGOs
MEDECINS DU MONDE	BOUTEILLER, Mr Girard	Logistician
	MADO, Dr	Medical Officer
UNICEF	PERKS, Mr Benjamin	Acting Head of Office
UNHCR	CUTTS, Mr Mark	Programme Officer
ZENICA REGIONAL HOSPITAL	BEGANOVIC, Dr Zahid	Director
WHO	ENVER, Dr Vreto	Assistant
	FRISCHE, Dr Lars	Head of Office
	MUJAKOVIC, Ms Amira	Driver
	VAVRA, Mr Vladislav	Assistant Logistician

Annex 4

TEAM MEMBERS

Dr Alfred Grech (Team Leader)
Director
International Institute on Aging
United Nations
Valletta
Malta

Dr Grech has had a distinguished career in public health. This has included posts as Chief Medical Officer and subsequently Special Adviser to the Ministry of Health in Malta. He has been Chairman of the Executive Board of WHO and Chairman of the Global Advisory Group on the Expanded Programme on Immunization and was a signatory to the Declaration of Alma-Ata in 1978.

Dr Brent Burkholder
Epidemiologist
Centers for Disease Control
Atlanta
USA

Dr Burkholder is a family practitioner and epidemiologist currently in the International Health Programmes Office, Refugee Activity, Centers for Disease Control, Atlanta, USA. He has worked with UNICEF and UNHCR in disaster situations and has participated on behalf of the United States in evaluation missions to Bosnia-Herzegovina. His next posting will be with the US Office of Foreign Disaster Assistance in Sarajevo.

Mr John Telford
Consultant
Emergency Management Limited
Laois
Republic of Ireland

Mr Telford is an independent management consultant. He has been head of UNHCR field offices in numerous locations and Senior Emergency Preparedness Officer. He has a wide background in programme evaluation and has designed and participated evaluations for the European Community and other donors. His particular expertise is in management training for field staff.

Dr Claude de Ville de Goyet (Executive Secretary)
Head, Emergency Preparedness and Disaster
Pan American Health Organization (PAHO)
Washington
USA

Dr de Ville de Goyet has been instrumental in forging WHO's policy and mechanisms for emergency preparedness and disaster relief coordination. He has coordinated the international emergency health response, in coordination with UN/DHA, to hurricanes, Gilbert, Hugo and Andrew, earthquakes in Mexico, El Salvador and Ecuador, conflicts in Central America and, most recently, the crisis in Haiti.

Annex 5

WHO EXTERNAL EVALUATION TEAM TRAVEL ITINERARY

TEAM MEMBERS[a]

	A	B	C	D
7–8 June 1994	Copenhagen	Copenhagen	Copenhagen	Copenhagen
9–10 June 1994	Zagreb	Zagreb	Zagreb	Zagreb
11 June 1994	Sarajevo	Sarajevo	Sarajevo	Sarajevo
12 June 1994	Zagreb	Split	Zenica	Zenica
13 June 1994	Belgrade	Mostar	Zenica	Tuzla
14 June 1994	Belgrade	Split	Zenica Sarajevo Split	Sarajevo
15 June 1994	Zagreb	Zagreb	Zagreb	Zagreb
16–17 June 1994	Copenhagen	Copenhagen	Copenhagen	Copenhagen

[a] Team members:
A: Dr Alfred Grech
B: Dr Claude de Ville de Goyet
C: Dr Brent Burkholder
D: Mr John Telford

Annex 6

FORMER YUGOSLAVIA
OBLIGATIONS EURO AND HQ 1992–1993
BY EXPENDITURE TYPE IN US$ MILLIONS AND PERCENTAGE[a]

	EURO		HQ		TOTAL	
	US$	%	US$	%	US$	%
Personnel	2.1	22.9	0.19	3.2	2.29	15
Duty Travel	0.07	0.7	0.02	0.3	0 09	0.6
Contracts	0.57	6.2	0.002	0 03	0.57	3.8
Local Costs[b]	0	0	0	0	0	0
Supplies	5.88	64.3	5.52	93.2	11.4	75.6
Other	0.03	0.3	0	0	0.03	0.2
Programme support costs	0.51	5.6	0 19	3.2	0 7	4 6
TOTAL	**9.16**	**100**	**5.922**	**100**	**15.08**	**100**

[a] Does not include contributions in kind.

[b] Please note that due to an error in coding in the accounting system, local costs have been included in Supplies component.

Annex 7

MANAGEMENT ISSUES

Implementation of the following proposals requires the support of a new Emergency Preparedness and Response unit in EURO (at least 2 professionals and support staff).

Human resources

Staff must be specially identified, recruited, briefed, trained (e.g. for coordination and the management of meetings and strategic planning sessions) and developed to perform the roles and functions specific to emergency management. Stand-by arrangements already in place between sister UN agencies and governments, NGOs and UN volunteers should be examined, in order to facilitate rapid and effective recruitment and staff development. Internal EURO volunteer rosters should also be established and maintained. Emergency focal points are required in EURO functional offices.

All field offices established during emergencies should have experienced administrative and finance staff. A field-based public relations officer is also required, at least for the initial stages of large emergencies. Local recruitment in the field, including that of international staff, should be expedited during emergencies.

EURO should review field staff security arrangements, procedures and support (manuals, training, equipment, etc.), in coordination with sister UN agencies.

Assignments to key posts in emergency operations should be for longer periods than at present, ideally at least nine months to one year.

Staff rules and regulations should be developed to support field staff in emergencies, as is being done by sister UN agencies; these should cover special compensatory leave, rest and recreation, etc.

Emergency management manuals, briefing kits, self-training modules and check-lists should be developed and widely disseminated (user-friendly, in electronic format where relevant, etc.).

Coordination

Coordination tools should be developed; these would include tables to identify and monitor resource gaps, questionnaires, implementation databases, agency profile forms, and guidelines on how and what to coordinate, all in a user-friendly format.

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Equipment and supplies

Regulations governing the procurement and stockpiling of materials and equipment should be overhauled, in order to facilitate the rapid supply of vehicles, office equipment, materials and communications. Specifically, stand-by office and individual staff survival kits, including communications, should be developed. Staff security equipment should receive special attention. Local purchase, including that of vehicles, should be facilitated.

Finance/Funding

Immediate access to emergency funds must be provided. Existing mechanisms (including the Department of Humanitarian Affairs' Central Emergency Revolving Fund (CERF)) are insufficient. A EURO emergency revolving fund is needed.

More delegated financial authority and accountability is required at all levels, particularly that of the lowest field office. A study of the relevant financial regulations is thus required. The complications and dangers associated with the transfer and management of cash require attention.

A review should be made of the impact of donors' requirements and conditions on EURO's capacity to respond to emergencies. The issue of more streamlined reporting needs particular attention. Where necessary, donors should be approached, in coordination with sister agencies, to request more reasonable reporting requirements.

Funds from programme support costs should be systematically channelled to the programme for which they were collected.

Stand-by arrangements for implementation

Negotiations should begin with NGOs and governments concerning stand-by implementation capacities, especially in the logistics area (assess potential partners, discuss criteria for partnership, etc.).

Annex 8

COMMENTS AND OBSERVATIONS BY WHO SPECIAL REPRESENTATIVES

All the Special Representatives acknowledge the value of the evaluation report. All welcome the overall positive assessment of the programme and agree with the recommendations made, except as qualified in the text below. The reservations they express relate mainly to paragraphs 25–58 in Part II of the report, on *Programme implementation and effectiveness,* and the text of recommendation 2. Their comments on the report of the external evaluation team (EET) have been combined and summarized below, following a structure which corresponds, paragraph by paragraph, to the EET report. Personal views are identified by the respective Special Representative's initials [DA, NR or HV].

Introduction

The basis of the funding of WHO's programme in the former Yugoslavia seems to be misunderstood [DA]. The whole of the infrastructure in the former Yugoslavia, including the salaries of international and local staff, was funded from donations from the international community and NGOs. Almost all, if not all, of these funds and supplies were donated on the understanding that they would be utilized for practical assistance to civilians (e.g. war wounded, refugees, displaced persons in the field, persons whose health was affected by sanctions), under the authority of WHO as the organization directly or indirectly accountable for their safe delivery. In the view of donors, WHO's advisory role was something which it should fund from its regular budget. Without the visibility generated by the fact that WHO was prepared to be involved in the field, there would have been no donations. Without donations, WHO would have been limited to one small office in Zagreb and its role would have been gravely limited and curtailed. It does not seem to have been appreciated that it was not, nor will it be in future, possible for WHO to fund significant operations in emergency humanitarian relief from the regular budget, and that donations are unlikely to appear without a visible hands-on role.

External evaluation of the programme

The EET had too short a period to undertake a proper evaluation of such a complex set of operations, covering such a wide area and involving the raising and disbursement of US $43 million (this is also the view of the external evaluators themselves). It did not have time, for example, to examine in detail the records of deliveries compiled by logistics staff or to visit any of their warehouses.

Programme implementation and effectiveness

Assessment of public health needs

WHO's work in this area was performed largely thanks to donations in kind, in the form of skilled people who could only come on a short-term rotation system. It is unlikely that WHO would have readily found a cash donor to expand their rather non-emotive and low-profile but extremely important work.

The statement concerning the health effects of sanctions is incorrect. From August 1992, when Dr Anthony Redmond prepared a report for WHO containing a detailed scrutiny of the effect of sanctions on the hospital services in Serbia, these effects were monitored by the Belgrade office. Dr Redmond's conclusion was that in 1992 a major part of the shortages was due to the economic deterioration in Serbia which had preceded the sanctions. The WHO Liaison Office in New York (acting on information from the Belgrade office as submitted through WHO headquarters) has been active throughout the war in advocating to the UN Sanctions Committee that health care supplies be excluded.

Scientific and technical advice

This section omits to mention two key areas of advice which had major significance for the population's needs:

(a) winter protection;
(b) clinical support, particularly in the techniques of wartime surgery.

The work of Lt Col Dr Risto Tervahauta (seconded from the Finnish Army) in offering guidance to the population in Sarajevo regarding frostbite and hypothermia during two winters by means of leaflets, broadcasts and the provision of supplies in that city, and the activities of Dr Margarhita Ruben and Dr Simon Mardell in supporting the clinical activities in Sarajevo (e.g. advice on the use of medical oxygen and Ketamine) and in Srebrenica were much appreciated and set an important example of solidarity with the medical and nursing profession in the former Yugoslavia. The WHO Special Representative visited all hospitals under bombardment to express support to staff on behalf of WHO and to determine needs.

Direct operational implementation: public health interventions; medical supplies and logistics; and rehabilitation

Water

With respect to water, the Special Representatives agree with the evaluators that WHO may have missed opportunities on the public health engineering side and did not adopt a sufficiently effective approach to water control. Nevertheless, in 1993 WHO undertook two major surveys, of water supply and quality respectively.

(a) in Sarajevo, by Lt Col Martigne, Director of Water Hygiene, French Army, on behalf of WHO;
(b) in Bihać and surrounding area by Dr X. Bonnefoy, WHO.

In the present phase of reconstruction, an operational role is being played in water supply and sanitation in Sarajevo and elsewhere by staff from the Nancy project office of the European Centre for Environment and Health (see document EUR/RC44/13 paragraph 7).

Public health interventions

For many public health interventions, WHO needs dedicated, specialist staff. The programmes on scabies, lice and tuberculosis control, nutrition monitoring and cold survival were successful because somebody had exclusive responsibility for them, while rodent control and influenza vaccination, and even health monitoring, were at times more problematic because these activities had to be carried out on top of many others. Public health interventions can generate lots of good will with few resources. They presume – but also help to establish – good working relations with local health institutions and personnel.

Medical supplies and logistics

EURO embarked on a new area of operations which of course caused problems. I [NR] think we became more trustworthy partners to the UN system, to NGOs and to the local health services because we had supplies to deliver. I think we tried to change as rapidly as possible to more specific items of supplies when we realized the diversity of needs. We experienced some difficulties in quickly changing the type of supplies, both due to the reluctance of donors to change from one sort of supplies in kind to another and also because of slowness in procurement. Yet another factor was that we did not have the sufficient resources to really assess, in a continuous and systematic way, the needs of each and every health institution and to establish a good enough monitoring and evaluation system on deliveries of supplies, both our own and those of others. If we have had 20% of the resources donated to us for that sort of activity and half of the remaining 80% as funds rapidly to be used for procurement of specific supplies, I [NR] think that at least in the period when I was in the area this would have been a great improvement.

The kits were designed for war conditions which had largely, but not completely, subsided by the time of arrival of the EET in June 1994. They are not intended for the reconstruction phase. During the war, the range of medicaments was almost universally welcomed and for several of the kits (e.g. mental health, chronic diseases, diagnostic, sanitary and vitamin kits) demands were never fully met. The WHO kits constituted one of the few sources of medicines of guaranteed efficacy and quality which were at least one year before expiry date. Mental health, chronic disease, sanitary and diagnostic kits were not available from any other sources.

The delays between the announcement of a donation and the arrival of kits ordered from the proceeds were indeed a serious problem. At times, these delays, bearing in mind the situation in the field, were heart-breaking. This problem must be solved in advance if WHO is to take on field responsibilities in emergency situations in future.

WHO was one of the few (possibly the only) agency to recognize the importance of the collapse of diagnostic facilities in the war zones and to provide technical and material assistance to hospitals in this area – largely with the help of donations from Denmark.

Between July 1992 and 1 July 1994 WHO's Supplies units delivered a very large volume of medical supplies, either directly or with the help of ICRC, NGOs or UNPROFOR (airlift). Secondary distribution improved during the period and by 1993 was satisfactory in many areas, notably Sarajevo. A substantial proportion of the supplies were not available from other organizations.

WHO's involvement in the supply of pharmaceuticals and other goods has been a matter of some debate even with some of the staff of the humanitarian assistance programme [HV]. Some feel that it has deprived us of valuable resources (personnel, time and money) to do other things that are closer to WHO's traditional role as a public health adviser. Others feel that it has been both a contribution to the health of the people and an essential precondition for gaining acceptance as an adviser. My views [HV] are closer to the latter. There are four interrelated issues: the impact of supplies on our work; the impact of supplies on the recipients; our efficiency and response to needs; and the adequacy of WHO's internal structures and processes for a supply operation. WHO got much of its resources specifically for supplies. It is wrong to think that the same resources could have been used for, say, health monitoring: they simply would not have materialized. We still find it difficult to get donations for our infrastructure. The (few) donors who have given unearmarked contributions may have done so only after having seen that we were active in the supplies area. It may be over-optimistic to believe that we would have got enough donations to launch a meaningful operation if we had limited our activities to a more restricted public health role. I [HV] doubt that the health care institutions and NGOs active in the field would so readily have provided us with data on needs if we had no way of responding to those needs.

The role of supplies varies both between and within countries. In Croatia, for example, a country with open access to the world market, WHO has no need to provide supplies, except in the UN protected areas where virtually nobody else is active. In central Bosnia, on the other hand, WHO has kept the local health care system alive, and in Serbia/Montenegro supplies were vital: in a very hostile and suspicious environment, WHO would simply have been laughed at or, worse, kicked out without supplies. There were not enough NGOs to take care of supplies. One easily overlooked issue is the difference between the central health authorities (i.e. the Ministry of Health in Sarajevo) and regional/local authorities. Knowing WHO from other contexts, the central health authorities can better appreciate and take advantage of WHO's advice than can the regional and local health authorities, who often have never heard of WHO. To gain their

confidence, one needs to do something tangible. Although the evaluation team explicitly doubts it, I [HV] feel that "hands-on" activities were necessary to convince many NGOs that we are a serious partner. Several field officers referred to this. It is not so easy to go to, say, Tuzla, roll up one's sleeves and say: "I am from WHO and I am here to coordinate and advise you" if we can't demonstrate that we know what we are speaking about (e.g. by having appropriate kits with high quality supplies). Finally, there is the issue of quality. The figures from Sarajevo show that overall 10–15% of voluntary donations were useless and another 20–30% of questionable value while WHO's supplies were always of high quality.

The decision-making chain is too long and too bureaucratic. The Special Representative, Zagreb, should have had a revolving fund – a request Sir Donald Acheson made very early on and repeated in his end-of-mission report. I [HV] think it is only with hindsight that we can suggest that NGOs could have been subcontracted to do some of this work.

The external evaluators mention two specific risks with regard to supplies: creating dependency (and also a prejudice for the future) and labelling WHO as "another donor". Both points are valid but can be counteracted by successful public health activities. I [HV] feel that we succeeded in this balancing act.

There has been some criticism that we have "stuck" with the kits for too long, whereas in fact we have changed the kind of supplies according to the changing needs. For instance, we shifted the balance from surgical supplies to drugs for chronic diseases. The procurement and distribution of hygiene kits has been accelerated when there has been a new influx of refugees. Nonetheless, the changes may sometimes have come too late. The wisdom of the suggestion to move to bulk supplies is, however, questionable. They will undoubtedly be cheaper and perhaps simpler to procure, but their distribution is resource-consuming. WHO cannot run a pharmacy. Perhaps the main lesson is that the kits were good during the acute crisis; once that phase is over, more "tailor-made" supplies can again be distributed.

Rehabilitation

The EET's interview with the ICRC coordinator (presumably recently arrived) does not take into account the fact that following the tragic incident in which the ICRC Senior Delegate was killed in an attempted first convoy to Sarajevo in May 1992, there was as a matter of policy no ICRC presence in that city until February 1993 and no possibility of ICRC providing rehabilitation facilities there or in most other parts of Bosnia until the spring of 1993.

In respect of mental health, I [DA] believe that WHO was indeed tardy in employing a full-time psychiatrist to assist in the rehabilitation and care of the mentally ill in the war zone. Such support was called for in the Wig report[a] and by two Special

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[a] Wig, N. *Present state of mental health institutions and services in the countries of the former Yugoslavia.* Copenhagen, WHO Regional Office for Europe, 1993 (unpublished document MNH/93.2)

Representatives, but for reasons already given, except in the field of medical supplies, cash donations to support WHO's activities were difficult to obtain.

Here I [HV] am more inclined to accept the criticism that we have entered a field where others could have done the work. WHO has very seldom provided clinical services; now we are fitting prostheses. These activities can, however, be defended on several grounds. We have done a good job. The rehabilitation project has been one of our most visible activities, has brought us lots of good will and has had important side effects. It would have been extremely difficult to change the very traditional approaches to physical rehabilitation if we had not had something tangible to offer. Once again, operational activities have bought us an "entry ticket" into our traditional role. They have had a clear national capability-strengthening component that would have been impossible without any supplies. It would probably have been difficult to tag that on to an operation carried out by somebody else (e.g. ICRC). Once again, I doubt that our donors would have supported a go-between role for WHO. There is unmet need. We actively cooperate with GTZ and Handicap International but still cannot meet all needs. WHO is the only agency that works with and supports the official health care system. NGOs tend to work in selected institutions or with restricted patient groups. They often prefer to establish parallel systems. Any sustainable solution must be part of the official system. The psychosocial rehabilitation project shows that it is easy to turn hand-on projects into health development activities. Virtually all proposed activities support long-term development. My [HV] conclusion is that WHO can very well undertake limited and well defined operational responsibilities where these activities can be used as a vehicle of change (e.g. the introduction of clean intermittent catheterization into a system that has hardly ever heard of it).

Management

The report recommends that delegation of authority from EURO to the field should be to field offices rather than to an area office like the one in Zagreb. In my view [NR] this is not an either/or choice. Both should have increased responsibility. In an area the size of Bosnia and Herzegovina and with the transportation situation we had in most of 1993, it would have been impossible to handle the operation without some coordination from Zagreb. Offices would have been needed in at least Sarajevo, Mostar, Banja Luka, Zenica, Tuzla and Bihac, each staffed with two competent international professionals to run a health and health services monitoring programme as well as coordination and evaluation of the health relief operations carried out by others.

Resource mobilization

The comparison made with UNICEF does not take into account the fact that its funds are not earmarked and are largely raised by public appeals and other fund-raising activities – not, like WHO's, largely from contributions from Member States. If WHO wishes to continue in the field of emergency humanitarian relief it will be necessary to have (a) an emergency fund in hand to "pump-prime" operations and (b) a system of fund-raising worked out and ready to go.

WHO would get more publicity from saving ten children with cancer than from providing the inmates of an 800-bed mental hospital with the basic psychopharmaca; nevertheless, it is surely the latter that is WHO's role.

Earmarked donations greatly reduce flexibility. To be flexible, one needs a strong and versatile infrastructure with the possibility of immediate deployment of unearmarked funds. The current situation illustrates the dilemma: we have drugs enough in the warehouse but no one to work full time on primary health care reform.

We did act in a specific area the evaluators mention – acquisition of medical literature. I [HV] identified this need already in my reports from Belgrade. We got a donation from the Finnish Medical Association for this purpose and, through the good offices of Nordisk Medicin, we have secured some leading medical journals for all the republics of the former Yugoslavia.

Relations with other partners

I [NR] think we did what we could and, as stated elsewhere, our relations with WFP and UNICEF were excellent. I agree that WHO should take a more active approach with regard to cooperation with the entire UN system in future emergency operations. I [HV] agree with the UNICEF Special Representative: "In general, cooperation among UN agencies had been good, but coordination is poor." We work well together and have good relations, but there is not enough formal coordination. This does, however, vary from place to place. The evaluators have not commented on this, but health coordination organized by WHO between UN agencies and NGOs has been very good, even excellent in smaller offices close to the crisis (Sarajevo, Zenica, Tuzla). All agencies know that they depend on each other. Coordination has been poorer in Belgrade and poorest in Zagreb. The reasons are clear: there are many more agencies there. Some actively resist coordination (e.g. small religious NGOs), others have such large-scale operations that they do not find the need or the time for coordination (e.g. ICRC and IFRC). They feel that their operations are self-contained. They also feel that the real coordination has to take place closer to the field – where it *does* take place.

UNPROFOR's main task – it is sometimes forgotten – is to make humanitarian assistance possible. There are two main ways of doing this: use of UNPROFOR's transport facilities and cooperation with UNPROFOR's health personnel. The nature and amount of such cooperation varies very much. UNPROFOR physicians are basically clinicians whose main responsibility is to treat UNPROFOR personnel. Depending on their interest and workload, they may participate in data collection, analysis of epidemics, needs assessment, public health interventions and provision of clinical care to the local population. If they have a public health inclination they often cooperate with the WHO field offices. They notify our staff of potential epidemics and other public health hazards, carry out joint needs assessment missions, etc. In UNPA East, the cooperation with the Belgian battalion has been particularly good. They assess the needs of the Baranja region, collect the supplies from our warehouse, distribute them to the

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local health care institutions, monitor the use of the supplies and carry out health education. Similar cooperation on a smaller scale occurs here and there.

Impact of humanitarian assistance on development activities

On more than one occasion the report highlights the view that WHO is "a development agency", as if this is exclusive of it operating as a humanitarian relief agency in respect of health care during emergencies. There is no justification for this view in the WHO Constitution or in the UN mandate for operations in the former Yugoslavia. Advising on "health development" issues cannot be WHO's "primary role" in a situation such as prevailed in Bosnia in 1992–1993 (or in Rwanda today!). During that period, the UN's goal of "preventing deaths, disability and suffering" and of focusing on the health of refugees and the inhabitants of besieged areas rightly took priority. WHO should accept its responsibility as the only UN agency eligible to take the health and health care lead roles in emergencies and, like UNICEF, should function in a double role.

During the UN humanitarian relief period, in which even-handedness in help for all the combatants was a prerequisite, serious (and possibly dangerous) misunderstandings could have arisen in Belgrade if the close relationships recommended had been developed with the liaison office in the Health Department in Croatia. It was a matter of policy that WHO should NOT share offices with the Health Department either in Zagreb, Belgrade or Sarajevo throughout the period of hostilities. The "arms-length" approach to all the warring parties was essential in security terms and correct.

Conclusions and recommendations

Brian McCloskey (quoted p. 18) says, and I [DA] agree, that if WHO wants to become operational it needs to change its organization as "emergency relief needs a loose, flexible, decentralized and devolved structure".

I [HV] should like to comment on some specific points made by the evaluation team.

Coordination of work. It has been excellent in the field offices, reasonably good in Belgrade and passable in Zagreb.

Coordination or control of incoming donations. The donor guidelines and guidelines for visits were a major improvement (very favourably commented on by USAID). Unfortunately, the health authorities, exposed to political pressure by an important donor, sometimes asked us not to adhere to the guidelines.

Health information. I fully agree that the collection, analysis and dissemination of valid health information is one of our most important tasks. The history of health monitoring shows that it is not easy to arrange. With very limited resources, we first tried the sentinel approach. It failed because the local health personnel did not consider information-gathering to be an important task when their institutions were filled with war-wounded. It also failed because we could not provide enough feedback. We then had a hiatus of almost half a year when we had nobody to take care of health

monitoring. Luckily, we found three qualified and energetic health monitors who contributed very much to establishing our position as a source of reliable health information. The provision of health information is a resource-consuming activity. It presumes qualified staff with long-term commitment and contracts. Local capability-strengthening is as important as the actual data collection; and good cooperation with NGOs and local institutions can partly substitute for WHO staff. We also learned that, under war conditions, information is a strategic commodity and can therefore be withheld. It was very difficult to get numbers for hospital beds, health personnel, people wounded, amputated, etc. Information on epidemics was the only kind of information that was readily shared.

Standard-setting WHO played an important role in standard-setting, particularly in specific areas such as tuberculosis. We also, however, had an indirect effect through our kits: the drug kits taught physicians accustomed to polypharmacy to be selective, while the laboratory kits also stressed the importance of parsimony and selectivity. It is very unlikely that an NGO acting on our behalf would have been able to get these messages across

The central role of Zagreb. Having been myself [HV] in Belgrade, I can easily understand the criticism levied against Zagreb. We have, however, continuously stressed the importance of serving the field offices. The critics of Zagreb may also forget that the consequences of the war are not limited to Bosnia and Herzegovina. We find amputated patients, nutrition problems, children with post-traumatic stress syndrome, lack of drugs, refugees with body lice, lack of medical supplies, etc., in all parts of the former Yugoslavia. It is therefore natural that most projects are still based in Zagreb. Zagreb is the only place that has access to all parts of the former Yugoslavia. Even today, the security and communications situation in Sarajevo is far too precarious to allow projects with "pan-Yugoslavian" implications to be transferred there.

Support to the official system. WHO has been unique in its constant support to the official health care system.

Health development activities. War-devastated countries deserve a very serious approach to supporting their health care reforms. The cost-efficiency of the proposed solutions is of paramount importance. We need to make a long-term commitment, ensure the necessary funds and ensure that the highest-level expertise is being made available to these countries.

The programme has certainly increased the "disaster consciousness" of EURO staff. It has highlighted the importance of a full commitment by the leadership, a strong yet flexible infrastructure (in coordination, budget and finance, personnel, etc.), clear communication channels, and the need to delegate a fair amount of authority to the field.

With the strengthening of the Coordination unit, we are beginning to get the infrastructure right but the rules and procedures are still a major impediment. We have

also had some difficulties because of an unclear mandate: for example, from the very beginning, we in WHO treated the entire population in all parts of the former Yugoslavia as our beneficiaries, yet, official UN documents speak only about refugees, displaced persons and besieged populations as beneficiaries. EURO, on the other hand, has stressed that this is a humanitarian assistance programme intended for the whole of the former Yugoslavia. .