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HEALTH, EMERGENCY PREPAREDNESS AND RESPONSE

REPORT

OF THE

INTERREGIONAL MEETING

Geneva, 13-16 April 1987

WORLD HEALTH ORGANIZATION

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1. EXECUTIVE SUMMARY

The meeting served the purposes of clarifying the Organization's role within the international community in emergency preparedness and response and reinforcing coordination within WHO. Present problems were surveyed, remedies proposed and paths of future cooperation were indicated.

The meeting emphasized the managerial and organizational aspects of preparedness and response to emergencies, whether acute or chronic, natural or man-made, involving epidemics or of a technological character. WHO and other organizations should, as an outcome, improve or build up institutional measures for emergency preparedness.

Particular attention was given to the necessity of improving the quality of information and its communication within WHO, among the organizations and agencies concerned, and between them and national authorities, as a means of more effectively preparing for, or mitigating disasters, as well as in responding to emergencies. The need for training in all aspects of emergency preparedness and response and for the participation of local authorities and communities was emphasized.

The discussions went beyond the consideration of disaster preparedness and response, because all phases of international action - the emergency rehabilitation and long-term development - are linked. Well-prepared long-term solutions would strengthen the capacity of countries to take development into their own hands and to cope with emergencies and disasters should they occur.

There was a consensus that emergency preparedness and measures taken by the health sector in response to emergencies should be an integral and indispensable component of the development process.

Each session of the meeting led to the formulation of recommendations designed to guide and develop the Organization's work in this field in the coming years.

2. INTRODUCTION

The Interregional Meeting on Health, Emergency Preparedness and Response was held at WHO headquarters from 13-16 April 1987

The participants in the meeting were focal points and officers in charge of WHO's regional emergency preparedness and response activities, their counterparts in the technical divisions and programmes at WHO headquarters and representatives of the United Nations and nongovernmental organizations which are the main partners of WHO in this field. The participants made brief statements describing their involvement and experience in emergency preparedness and response where appropriate and the extent of their collaboration with WHO.

Professor L. Kaprio, Special Adviser to the Director-General and Professor M. Lechat, Dean of the Faculty of Public Health, University of Louvain, Brussels, served, respectively, as chairman and vice-chairman. Mr A. Curnow was appointed as rapporteur. A list of participants is annexed to this report.

In welcoming the participants on behalf of the Director-General, Mrs I. Brüggemann, Director, Programme for External Coordination, emphasized the shift in WHO's activities in recent years from ad hoc responses to emergencies to the promotion of preparedness at the country, regional and global levels. WHO aims at a practical transfer of past experience into present action, as a means of

strengthening the capacity of the Member States to integrate emergency preparedness and response in their overall development. WHO identifies information support and the training of key national and international staff in emergency preparedness and relief operations as its major contributory role, with information as the most important link between the event and the action.

In his opening address Professor Kaprio emphasized that against the background of the Africa crisis and the increasing frequency of technological disasters, WHO has to increase its efforts for the promotion of the health management of disasters, integrating preparedness and response to emergencies in the primary health care system, and coordinating its activities with other agencies in the matter of resources and expertise.

Local communities carry the first responsibility for dealing with an emergency, they must be armed with appropriate information to mitigate the impact when disaster strikes and there should be mechanisms to reduce their vulnerability. Primary health care structures and the district health system are the appropriate means for an integrated and coherent response in disasters. It is, however, also necessary to look more closely at the administrative structures on which depend the organization of emergency preparedness and response.

3. RECOMMENDATIONS OF THE INTERREGIONAL MEETING ON HEALTH, EMERGENCY PREPAREDNESS AND RESPONSE

The meeting recommended that WHO should:

1. Cooperate with the Member States to create or strengthen their mechanisms for emergency preparedness and response so that the governments are in a position to consolidate national efforts with bilateral and multilateral offers of assistance as well a with assistance from nongovernmental organizations, and to direct the whole as a concerted and effective programme.

2. Encourage and assist Member States to integrate emergency preparedness and response in district health services, with a strong community involvement through primary health care.

3. Continue to encourage disaster-stricken countries to critically assess and specify the material and other support they require in a given emergency, and to coordinate with donor countries and organizations to adapt their programmes of assistance to meet these requirements.

4. Advise governments on the identification of health hazards, including high-risk technological activities, on the establishment of community profiles and on practical preventive measures to avoid or reduce the hazards.

5. Develop the Organization's capacity to provide management and technical guidance on health aspects of emergency preparedness and response to Member States, to United Nations and to other organizations and improve external and internal communication systems.

6. Reinforce its emergency preparedness programme by promoting and facilitating the direct transfer of experience between regions and Member States; increasing collaboration with nongovernmental organizations; enlarging the network of collaborating centres, particularly in the developing regions; and establishing a pool of expertise available on demand;

7. Streamline and strengthen its emergency preparedness and response programme at the global, regional and country levels; by establishing and clarifying the functions of the regional offices and of the WHO Representatives in guiding, advising

and supporting the activities and by making a concerted approach to prospective donors for extrabudgetary support.

8. Seek the support and views of the Organization's governing bodies and of the Member States, report on activities carried out under the programme and establish guiding mechanisms for the programme including an expert advisory panel for emergency preparedness and response.

9. Strengthen the Organization's internal coordination machinery by joint planning and implementation to associate such emergency preparedness and response activities that deal with technological disasters, epidemics and slowly developing disasters such as famine and refugee situations, with the activities of the technical programmes.

10. Encourage, through case studies and research, the analysis of past emergencies and the action that was taken, in order to learn from experience and to create an "institutional memory" as a basis for responding to or averting future disasters.

11. Coordinate with governments, United Nations and other organizations in the collection of information on emergencies and improve epidemiological surveillance and early warning systems, including early detection of epidemics.

12. Expand public education and information exchange, disseminating clear and unambiguous messages which are based on the resolutions and recommendations of meetings organized by WHO or by other organizations concerning emergency preparedness and response. Keep the media informed by participating in seminars and workshops and by means of briefings during emergencies.

13. Support and coordinate training programmes in health emergency preparedness and response, inter alia through preparation of training modules and materials as well as standard messages and guidelines; encourage the development of training programmes for health personnel in disasters, including graduate and postgraduate courses.

14. Cooperate with other agencies of the United Nations system, bilateral donors and nongovernmental organizations, in the coordination of international emergency relief in support to governments; and give leadership to the international health sector and harmonize its contributions.

15. Maintain and reinforce its cooperation with its major partners in refugee matters in development of health programmes for refugees and other displaced populations and in surveillance of their health status and help to integrate services to refugees in the health programmes of their host countries.

4. EMERGENCIES, HEALTH AND DEVELOPMENT

4.1 United Nations approaches

United Nations system views of emergency preparedness and response in relation to long-term development, with particular reference to the health aspects, were presented by representatives of the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), and the United Nations Development Programme (UNDP).

WHO and UNHCR work together in the field of emergency preparedness and response. Recent examples include the formulation of a health programme for Afghan refugees in Iran, the drawing up of operational guidelines for health and nutrition programmes for refugees, and the development of emergency health and immunization kits. There is room for further cooperation as, for example, in the early detection of epidemics, in providing information to UNHCR on the physical vulnerability of large migrating groups of people and in improving the health climate for refugees returning to their

countries of origin. UNHCR would welcome help from WHO in establishing standards of assistance and in integrating health care programmes for refugees in the national health services of host countries.

WHO and UNHCR should make additional efforts to recognize their areas of interdependence and provide mutual reinforcement to one another to avoid duplication of effort, as recommended by the Group of 18.

UNICEF and WHO complement one another and assume separate responsibilities in working towards the common goal of improved health for children and their mothers. UNICEF believes that the mobilization of all existing resources to bring basic protection to the lives and development of children using the low cost strategies now available is a practical and affordable way of meeting many short-term emergency needs and at the same time of building towards longer-term development.

Governments of developing countries are submitting an increasing number of proposals to UNDP for projects in the fields of disaster relief, emergency preparedness and prevention. UNDP stresses the importance of developing the infrastructure of countries for disaster preparedness, including the training of staff responsible for management. UNDP foresees a reassessment of its programme to focus on the source and effects of disasters, and on the development of better complementary links between its programme and those of other multilateral organizations as well as bilateral efforts. In the UNDP view, the United Nations system needs a coherent strategy to meet the emergencies created by endemic disasters such as recurring drought. A focal point within each agency of the system would reinforce collaboration in programmes for emergencies. In the field, the UNDP Resident Representatives represent the Office of the United Nations Disaster Relief Coordinator (UNDRO) vis-à-vis host governments. As Resident Coordinators of the UN system for development activities, the Resident Representatives can assist governments in emergency situations by ensuring coherent and coordinated action on the part of the international community.

It was proposed that one way to avoid duplication of effort between organizations would be for the governing bodies of the UN agencies working in the field of emergencies to be informed how the existing informal coordination functions. It was noted that formal agreements between WHO and UNHCR and between WHO and UNDRO are at present being prepared.

4.2 Strategies and role of WHO in emergency preparedness and response

WHO has a mandate for emergency preparedness and response in its Constitution. The World Health Assembly in 1981 and 1985 adopted resolutions which emphasize the fundamental importance of preventive measures and preparedness, the integration of emergency response with regular WHO programmes, and the linkage with development. The two main objectives are to promote emergency preparedness and response in the Member States within the Health for All strategies and to provide timely and appropriate response to emergencies in collaboration with the Member States and other organizations.

In the discussion it was pointed out that the emphasis on emergency preparedness in WHO activities serves as a reminder that the Health for All strategies and primary health care embrace much more than the provision of health services; a breadth of scope which will be reflected in community and country health activities.

The stress in emergency preparedness should be on community participation, local planning and the development of self-reliance. The identification of hazards, the assessment of risks, the organization and management of action in emergencies and the monitoring and evaluation of the impact of such action are in the first instance a community responsibility. Governments should give priority to training and the

development of management skills at that level in order to strengthen the capacity of communities to prepare for and to cope with disaster situations, and if possible to mitigate them.

WHO is trying to enhance its technical cooperation and improve coordination of its response to emergencies and it will integrate emergency preparedness and response in its health development programmes. As a consequence, the emphasis has shifted from the mounting of health relief operations to promotional and developmental activities, from vertical action in emergencies to an integrated and coordinated managerial approach.

In putting the emphasis on disaster preparedness, WHO shares the widely-felt concern for the cost-effectiveness of the funds put at the disposal of international organizations. The integration of action relating to emergencies with the development process, while logical, nevertheless creates a problem for potential donors. Is disaster preparedness relief, because it is linked to emergencies or development-oriented, because it involves training? The problem has to be addressed if adequate funding is to be found. WHO must argue effectively that emergency preparedness and response are indispensable to long-term economic and social development and that at headquarters and in the regions the Organization has the necessary will and capacity to implement the programme.

Chronic emergencies, such as famine, as well as other natural disasters, are matched by acute financial shortages which make it impossible for the countries concerned to maintain and rehabilitate their health infrastructures. The rehabilitation of run-down health services, which are usually fragile and inadequate before emergencies occur, has to be treated by WHO as a priority task, which can only be achieved by giving emergency preparedness a development setting.

The importance of district health systems to disaster preparedness lies in the monitoring of health status and key risk factors, the identifying and monitoring of vulnerable groups, better organization and management of interventions, and the monitoring and evaluation of their impact. In promoting district health systems, WHO is concerned mainly with training and the development of management skills.

The evaluation of WHO policies and strategies for emergency and development support should take account of their impact in terms of social relevance, equity and quality, as well as their statistical effectivenes. The poor of the poorest countries, it was pointed out, suffer more from disasters than others. Relief assistance does not necessarily reach the most vulnerable groups. The least privileged are also those most affected by the long-term consequences of disasters and by the repercussions when relief assistance has unintended negative effects.

Relief agencies are increasingly aware of the need to balance urgent measures and long-term assistance in order to reduce the vulnerability of populations to natural hazards. They have also learned that the local community and local authorities are the first to respond to an emergency and that in the area of disaster prevention, experience has shown how important it is for the people most likely to be affected to act in their own defence. Foreign assistance arrives later.

If emergency aid to disaster areas is substituted for the capacities of existing local organizations, existing development financing schemes and community participation, the danger of economic dependence of the whole society and not just the affected groups is increased, and its development potential weakened.

Relief operations are often hindered by poor communications. Communications can be improved at a small fraction of the total amount spent on emergency aid. A positive cost-benefit ratio may be expected because available resources would be

better used. Greater access to satellite communications may be a component of an improved approach both by making it possible to share facilities used by the media, and by employing small portable stations. A proposal to test this approach has been prepared by WHO.

The emphasis on disaster preparedness has consequences in the field of public information and education for health. Where information messages concerning emergency preparedness are to be communicated to target-groups, WHO notes that communicators need to use political finesse; it is often a sensitive matter to draw attention to the risks of disaster. Those who are entrusted with communication on the issue of preparedness should have experience of acute situations. When emergencies arise and response is to be made, a public information service has to establish its credibility in the early stages, and to be prepared to cope with the problems of false and withheld information.

5. PREPAREDNESS IN MEMBER STATES AND IN WHO

5.1 National Disaster Preparedness

The Ministry of Health and Family Welfare of India organized a workshop on disaster management with the cooperation of WHO at Nagpur in October 1986. The workshop, which brought together representatives of many sectors in the central and state governments, serves on the regional level as a model for other meetings which are to be held in Bangkok and Jakarta. India is subject to floods, drought, cyclones, landslides, tidal waves, and severe heat and cold, and has also experienced major industrial catastrophes. All disaster situations present vast problems in the magnitude of their potential human impact. The structures developed by the Government of India to deal with natural calamities as well as man-made disasters were described to the meeting, with particular reference to the emergency medical services and relief provided by the Ministry of Health and Family Welfare.

Tunisia has instituted a national disaster management programme. An Emergency Coordination Committee has been created with the Minister of Health as chairman. The civil protection organization serves as inter-sectoral coordinator. Similar committees have been established at the provincial level. A master plan to cover action in connection with disasters, including forecasting and prevention, has been drawn up, and the organizational capacity for disaster management is being strengthened. Tunisia has signed conventions with Algeria, France and Italy covering mutual assistance in the event of catastrophes.

The early warning and planning service of the Relief and Rehabilitation Commission (RRC) of Ethiopia correctly predicted the famine of 1984-86 but official appeals for assistance met with a slow response. Only when the images of disaster had been projected on television screens did aid begin to flow from the international community. A succession of emergencies has given the RRC the experience necessary to sharpen its response in relief operations, rehabilitation and the coordination of aid. Health has a subsidiary role in RRC activities and all UN agencies and nongovernmental organizations participating in disaster relief and rehabilitation deal directly with the RRC. The Ministry of Health assesses the credentials of all nongovernmental organizations and gives them clearance to work in the health field, issues drugs in collaboration with the RRC, prepares drug and medical supply requests, participates in tripartite agreements with NGOs and the RRC for the rehabilitation or establishment of health centres and establishes guidelines. The Ministry had insufficient trained staff and funds to run health services in the large number of relief shelters and settlement areas established during the famine.

A WHO team visiting Ethiopia at the height of the famine noted the lack of a standardized approach in health reporting and monitoring, and the difficulty of identifying who was responsible in the emergency health field, and stressed the need

for a health coordinator. WHO appointed a health coordinator who played an important role in coordinating and streamlining health activities in the shelter areas.

The United Nations Emergency Prevention and Preparedness Group, established on 1 January 1987 will strengthen and support the capacity of the RRC and other Ethiopian Government agencies as well as international and bilateral institutions in emergency relief, preparedness and prevention.

Points made in the discussion included the need for a focal point in disaster preparedness and response in WHO regional offices, as well as the need for support from WHO in training and research and in the collection and dissemination of data to be used in emergency preparedness and response. It was suggested that countries which are formulating national emergency preparedness plans may usefully study the planning procedures adopted by other countries with well-established programmes.

5.2 WHO activities and programmes in emergencies and disasters

The WHO global action programme in emergency preparedness and response provides for the establishment of guidelines for information and communication within WHO and between WHO and other organizations, and the establishment of early warning systems. The Organization's capacity for epidemiological assessment is being improved. Training programmes and materials are being prepared. Closer coordination has been established with other organizations in the field of emergency health relief. Studies and research on previous disasters are being undertaken or encouraged, and the findings will serve as the basis for improvements in the programme.

The unit responsible for disaster preparedness and management at WHO headquarters is in the mainstream of coordination. The unit supports the initiatives of the WHO regional offices, coordinates their activities, collects and processes information, provides communication with other organizations and is responsible for the overall development of the programme.

There is a need to identify and clarify the role of regional offices and WHO country representatives in guiding, advising and supporting donor countries and organizations interested in participating in the health aspects of emergency preparedness and response.

5.2.1 Regional Office for the Americas (AMRO)

The Americas regional programme is well established. It aims to improve the preparedness of health institutions through contingency planning, training, public education and coordination with other sectors. Services to Member States include the provision of technical manuals, guidelines and training materials, the organization of international workshops and courses, a newsletter, simulation exercises, the short-term services of experts in disasters and disaster research and evaluation. In response to disasters, AMRO assesses health needs and supplies necessary information to potential donors, coordinates international health assistance, formulates and carries out rehabilitation projects, and provides expertise in the management of temporary settlements, sanitary engineering, water supply, disease surveillance and control, as well as other public health concerns. Voluntary contributions provide 90 per cent of the funding for the AMRO emergency preparedness programme.

5.2.2 Regional Office for Europe (EURO)

The Regional Office for Europe has strengthened its accident prevention programme to cover disaster preparedness. The main activities relate to management, with technical aspects of disaster preparedness developed within related regional programmes: environmental health, mental health, nursing and primary health care. The aim of the programme is to enhance national preparedness in coping with health aspects of disasters and major accidents in the framework of community participation

and primary health care. Guidelines on protecting the health of the community in disasters are being drawn up. Regional and national courses on disaster preparedness are being held. Country profiles and indicators for the rapid assessment of health risks and needs before and following a disaster are being prepared. Six countries are being helped to create national plans for disaster preparedness. The services of a task force of assessors are available to assist Member States at all stages, from preparedness to rehabilitation after a disaster. A manual of guidelines on action to be taken by the regional office at the time of a disaster is being prepared, and an in-house task force has been created which has already worked successfully in major disasters, including the nuclear accident at Chernobyl.

5.2.3 Regional Office for Africa (AFRO)

Workshops were organized in 1985-86 to train health professionals from Members States and to brief WHO staff, including WHO representatives, on the contents of the emergency preparedness programme and on their responsibilities in responding promptly in emergency situations. Technical officers and associate professional officers are to be appointed in Africa for the programme. A regional centre for emergency preparedness and management is to be established in Addis Ababa. A regional action plan, first drafted in 1985, is in the process of being revised and further developed.

5.2.4 Regional Office for the Eastern Mediterranean (EMRO)

A plan of action for emergency preparedness and response has been drawn up for the Eastern Mediterrean region. The objectives are to assist countries in the region to achieve self-reliance in emergency preparedness and management at all organizational levels, and to provide timely and appropriate response in emergency situations. WHO will support Member States in formulating their plans for the health aspects of emergency preparedness and management, and will assist in the training of nationals in emergency management. WHO will collect information for country profiles as a basis for monitoring, evaluation and prompt response to emergencies. Links between refugee health and general health programmes will be strengthened through collaboration between governments, UNHCR and WHO. WHO will support governments in the rehabilitation of health services after emergencies. An emergency relief committee has been established in the regional office.

5.2.5 Regional Office for South-East Asia (SEARO)

Disasters in many parts of the South-East Asia region are of an endemic nature. Some countries have taken the initiative to develop their own national preparedness and response programmes. Information systems for emergencies and the flow and exchange of information between the country, regional and global levels need improvement. Attention should be given to the training of national and WHO staff. Funding is being sought for a regional emergency preparedness and response programme which will identify and promote preventive measures so as to minimize the health hazards and risks to the populations directly or indirectly affected, and to collaborate with the Member States and the international community in developing and refining the health aspects of emergency relief work.

5.2.6 Regional Office for the Western Pacific (WPRO)

Activities of WHO for emergency preparedness in the Western Pacific region have been sporadic. A regional emergency preparedness and management programme and plan of action will be based on a review of national programmes in the region, on the identification of the need for WHO support and the resources required, and on the compilation of country health information profiles. In the small island countries of the region emergencies usually involve not more than a few thousand people. Assistance is, for this reason, on a small scale.

5.2.7 Collaborating centres

The collaborating centres provide support to WHO in its emergency preparedness and response programme. At present there are two collaborating centres in this area: the Centre for Research in the Epidemiology of Disasters, University of Louvain, Brussels; and the Centre for Refugee Health and other Displaced Communities at the London School of Hygiene and Tropical Medicine. More collaborating centres will be added to create a network covering all regions. Universities and other institutions are encouraged to include the subject of health in emergencies and disasters in their training curricula, and individual experts are invited to participate in the assessment of needs, the coordination of field activities and training. WHO is already working closely with the Asian Disaster Preparedness Centre at the Asian Institute of Technology in Bangkok.

6. SPECIAL ISSUES IN DISASTERS

6.1 Food shortages and famine: Planning and surveillance

Food aid constitutes the bulk of international assistance in chronic emergencies, including famine, with the need to maintain nutritional levels as the main criterion. However, it is not always easy to determine the cut-off point of an emergency - for which the food aid is intended - and the start of the post-emergency rehabilitation period. The danger is that if the distribution of food continues, an attitude of dependence is created, and the affected population expects its government and external agencies to go on supplying its essential needs.

Famine strikes essentially the rural poor and is linked to long-term poverty, neglect in development, inefficient use of land, the prevalence of debilitating diseases and malnutrition. Food aid can be used as one means of breaking the cycle of under-development. It can be targetted as a development resource to those in greatest need and be used to assist clearly defined projects with specific objectives. It may, for example, be used after the acute stage of an emergency as an incentive to community action, as a support to primary health care. By relating food aid to preventive health action, the health sector is able to make a greater contribution to development and help to avoid the negative effects of ill-planned food distribution.

Malnutrition is not linked solely to the amount of food available; it is related to specific health problems which must be identified. The significance of malnutrition levels varies according to the overall situation, and the macro-picture is often more significant than a narrow interpretation of food needs.

Nutritional monitoring is the only way to determine the regions and target populations for food distribution, and the types and quantities of food to provide. Yet, in many disaster-affected countries, nutritional surveillance does not play a significant role in the assessment and implementation of response to emergencies. In most African countries, the national health structure is incapable of responding to this requirement, which has to be supplied by external means. The problem is to have the desired impact with the limited resources available, but in the absence of nutritional surveillance, external agencies are under great pressure to make general distributions of food, which are ineffective.

The World Food Programme has close ties with WHO. Further cooperation might take the form of helping governments to set up national surveillance systems with plans to identify the areas where there are extreme food shortages and, in those areas, which people are in need of emergency food distribution.

A conference on nutrition in times of disaster will be held in Rome in January 1988. Private voluntary organizations, United Nations agencies, bilateral aid agencies and individuals and organizations in developing countries working on

disaster problems will be invited to discuss the identification of target groups in nutritional need, the determination of foods and the quantities to be distributed, and the monitoring and evaluation of effectiveness of nutrition programmes. Training, and the handling of all nutritional issues as they relate to sudden catastrophes will also be discussed.

The planning of response to emergencies should be started as part of the process of surveillance, and in planning it is necessary first to set clear objectives which will determine the approaches to be adopted. Consideration must be given to putting in place at an early stage the defence mechanisms of the population, and to defining what is expected of systems to prepare for emergencies.

6.2 Health care and displaced populations: organization of services

Mass movements of population and concentrations of refugees increase enormously the risk of epidemics of communicable disease. The outbreaks of cholera, meningitis and measles in Sudan in 1985 provide recent examples. The spread of deficiency diseases, such as scurvy, is also a feature of refugee situations, and has been noted in Sudan, Somalia and among Cambodian refugees. The risks of disease outbreaks are often predictable.

International agencies should make greater efforts to combine in the assessment of refugee needs. If this can be done, it may be possible for the agencies to harmonize their efforts more effectively at the planning and action stages. A formal means of consultation among the agencies concerned with refugee problems would lead to better coordination, including agreement on the form of risk assessment and on working together in the field at the time of an emergency.

Among the specific objectives of consultation should be standardized policies and protocols on information collection, training and forms of treatment, the designation of lead agencies, the establishment of channels of communication, and the decentralization of the health programmes. WHO should have a major role in the coordination of health assistance to refugees.

At the present time, the quality and variability of assessments provided by persons with differing professional backgrounds and levels and degrees of experience create problems. There are also difficulties in finding agreement on priorities for action as, for example, between nutrition and sanitation.

The temptation must be avoided in dealing with refugee situations of creating parallel health services furnished by external agencies in cases where the national health systems are weak. Priority should be given to strengthening the national health service capacity, so that it can effectively meet the requirements of the national community as well as those of the displaced groups. The training of nationals, in particular those who are expected to coordinate and manage health programmes at the field level, is an important task for the international community.

6.3 Public health and disasters

Contingency planning and the setting up of an early warning system are essential if health service is to cope rapidly with an outbreak of disease. Contingency planning for emergencies should fit into the normal administrative structure as an element of the government's day-to-day dealings with the health services. The national health authorities for their part should consider communicable disease control as an integral part of health service, bearing in mind that success in dealing with epidemics depends largely on the state of preparedness achieved in advance of the need to take action. Priority in planning should be given to preparedness for diseases which have already caused epidemics in the region concerned.