



HEALTH IN EMERGENCIES

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Challenges to reproductive health in emergencies

by Wilma Doedens WHO and Kate Burns, UNHCR

What is the challenge?

Implementing comprehensive reproductive health (RH) care for a population is never a simple matter, but emergencies and displacement pose special challenges for delivering this kind of care. Refugees and internally displaced persons (IDPs) have the same reproductive health needs as non-displaced people. However, the factors that forced them to flee also render them extremely vulnerable to reproductive as well as to other health problems. Forcibly displaced persons have left behind the support of traditional values, extended families and familiar ways of life. They have often lost their loved ones, their possessions, their livelihoods, their social status and even their human dignity. The changes wrought by displacement - a lack of traditional support and role models, different cultural pressures to reproduce lost members of the community and changing roles and identities of men and women along with their roles in society - are major barriers to implementing adequate reproductive health programmes. In emergencies, mortality and morbidity from reproductive causes may increase, life transitions such as the one from adolescence to adulthood are made more difficult, and important aspects of RH programmes, such as the integration of men are major challenges.

International response

WHO is a member of and provides technical support to the Inter-Agency Working Group for Reproductive Health in Refugee Situations (IAWG). This group was established in 1994 under the co-ordination of UNHCR and includes approximately 30 UN agencies, NGOs, academic and donor institutions. The IAWG developed the Minimum Initial Service Package (MISP), which incorporates all necessary elements to provide basic reproductive health services during the first phase of an emergency, with the aim of reducing mortality. A person or organisation to coordinate the reproductive health response and planning for comprehensive reproductive health service provision, as soon as the situation stabilises, are part of the package.

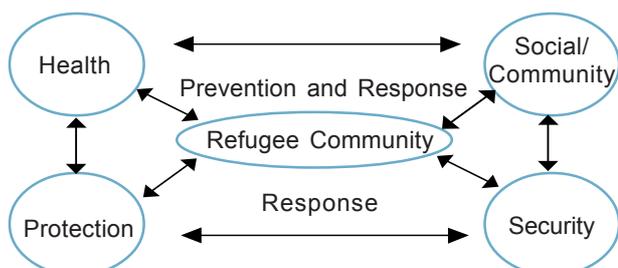
The MISP and other reproductive health measures to be taken in the emergency and the post-emergency phase are described in "Reproductive Health in Refugee Situations, an Inter-Agency Field Manual" produced by the IAWG (see page 2). The medical supplies needed to implement these measures are assembled in the "Reproductive Health Kit for Emergencies", developed by the IAWG and assembled and stockpiled by UNFPA. The IAWG meets twice a year and continues to address RH problems in emergencies.

This year, WHO has produced a guide for programme managers: "Reproductive Health during Conflict and Displacement", which is complementary to the IAWG field manual.

An example: Sexual and gender-based violence

At every stage of a conflict, women and adolescent girls and boys are vulnerable to sexual and gender-based violence. Rape and other forms of violent assault are often used as weapons of war. Women and girls are forced to offer sex in exchange for food, shelter or protection. Emergency contraception and other medical and psychological care are rarely available. Sexual and gender-based violence has a disastrous effect on people's physical and mental health. Some of the psychical effects include unwanted pregnancies, unsafe and complicated abortions, HIV/AIDS and other sexually transmitted infections (STIs), sexual dysfunction and injuries. Psychological ill effects can include anxiety, post-traumatic stress disorder (PTSD), depression, and suicide. This may lead to impaired social and community health, such as lack of women's income, interrupted education of adolescents, infanticide, and delayed community reconciliation and reconstruction.

Multi-sectoral approach to programmes



The challenge to effectively prevent and respond to sexual and gender-based violence is in employing a multi-sectoral approach, involving protection, security, community and health sectors.

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While it is not proven, it seems likely that the incidence of sexual and gender-based violence, specifically rape, may increase in the early phases of an emergency, particularly during flight. However, the grouping of people in refugee or IDP camps also offers an opportunity for prevention and community education. Preventive measures such as careful design and layout of camps (i.e. adequate lighting, security patrols, and the planning the location of basic services and facilities in such a way that this does not expose women to attack) can reduce the risk of sexual and gender-based violence.

Other ways to prevent sexual and gender-based violence and to reduce the negative health impact this has on individual survivors include information campaigns (taking into account cultural sensitivities, ethics and the medico-legal circumstances in the host-country), along with ensuring easily accessible, private and confidential health services for survivors.

There are a number of tools available to help meet the challenges of sexual and gender-based violence in emergency situations. General guidance is available through the UNHCR's "Sexual Violence against Refugees - Guidelines on Prevention and Response" which provides useful advice on camp planning and education and information campaigns. Specific programme guidance is provided in the inter-agency field manual and the WHO guide for programme managers (in preparation).

Furthermore, WHO, in collaboration with the IAWG, is developing a guide for the "Clinical Management of Post-Rape Survivors", which outlines best practices for managing the health implications of rape. The protocol details essential components of post-rape medical care such as:

- √ Forensic evidence collection;
- √ STI evaluation and treatment;
- √ Pregnancy risk evaluation and prevention;
- √ Crisis intervention;
- √ Care of injuries;
- √ Referral to other services:
- √ The needs of special groups, such as children and pregnant women.

Conclusion

Many agencies working in the field implement only one element of a reproductive health programme; very few deliver comprehensive reproductive health services, integrated into primary health care. Effective reproductive health programmes safeguard basic human rights of displaced people - such as the right to life and health, the freedom to marry and determine the number, timing and spacing of children, and the right to liberty and security of the person, including freedom from sexual violence and coercion.

What is reproductive health?

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters related to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

International Conference on Population and Development - Cairo 1994; Programme of Action, para 7.2

Comprehensive reproductive health care includes:

- Family planning
- Safe motherhood: ante-natal, safe delivery, post-natal care
- Gynaecologic care
- Sexually transmitted infections/HIV/AIDS prevention and treatment
- Sexual violence prevention and management
- Active discouragement of harmful traditional practices (i.e. female genital mutilation)
- Adolescent reproductive health programmes

An inter-agency effort

Providing comprehensive and high-quality reproductive health services requires a multi-sectoral, integrated approach. Protection, health, nutrition, education and community service personnel all have a part to play in planning and delivering reproductive health services.

The *Inter-Agency Field Manual on Reproductive Health in Refugee Situations*, which is the result of a collaborative effort of many UN agencies, governmental and non-governmental organisations and refugees themselves, is intended for use in refugee situations. It may also be of use in refugee-like situations, such as situation with internally displaced persons or returnee-affected areas.

The Manual includes chapters on safe motherhood, sexual and gender-based violence, sexually transmitted diseases including HIV/AIDS, family planning, reproductive health of young people and surveillance and monitoring. The information contained in the Manual is based on the normative, technical guidance of WHO.

The Manual is available online at: http://www.who.int/reproductive-health/publications/interagency_manual_on_RH_in_refugee_situations/index.en.htm

FOCUS ON REPRODUCTIVE HEALTH

Family planning needs

Refugee women and men should be involved in all aspects of family planning programmes and the programmes should be carried out with respect for various religious and ethical values and cultural values within the refugee community. From the earliest stages of an operation, organisations should be able to respond to refugees' demand for contraceptives.

In setting up services, an assessment of the attitudes of different groups is essential, and contraceptive prevalence should be ascertained. Service sites need to be established with the participation of the refugee or displaced population, along with logistics and record keeping systems. Health and community workers trained in family planning service delivery must be available. The early and continued involvement of men is crucial.

Full details can be found in Reproductive Health in Refugee Situations, An Inter-Agency Field Manual. The Manual is available online at: http://www.who.int/reproductive-health/publications/interagency_manual_on_RH_in_refugee_situations/index.en.htm

Sexual and gender-based violence

Physical, sexual and psychological violence occurring in the family and in the community, including battering, sexual abuse of female children, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence, violence related to exploitation, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women, forced prostitution and violence perpetrated or condoned by the state.

Articles 1 and 2 of the UN Declaration on Violence against Women, 1993

Role of the health sector in prevention and response to sexual and gender-based violence (SGBV) in refugee situations

At every stage of a conflict, women and adolescent girls and boys are vulnerable to sexual and gender-based violence. While rape and other forms of violent assault have often been used as weapons of war, the problem seems to be worsening. Many women and girls are forced to offer sex in exchange for food, shelter or protection. Emergency contraception and other medical and psychological care are rarely available.

Sexual and gender-based violence has a disastrous effect on people's physical and mental health. Some of the psychical effects include unwanted pregnancies, unsafe and complicated abortions, HIV/AIDS and other sexually transmitted infections (STIs), sexual dysfunction and often injuries. Psychological ill effects can include anxiety, post-traumatic stress disorder (PTSD), depression, and suicide.

The role of the health sector should not be confined to merely responding to the victims' needs; the health sector has an essential role to play in the prevention of SGBV in refugee and IDP settings. Education and community outreach can be used to encourage victims to seek help as soon as possible after an incident. Displaying posters and pamphlets in health clinics is an effective way to advertise services available.

The health sector cannot work in isolation and one of the challenges to effective prevention and response to SGBV is to co-ordinate a multi-sectoral response, involving protection, security, social community and the health sectors.

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SGBV monitoring in the United Republic of Tanzania

United Republic of Tanzania: The results of an International Rescue Committee (IRC) assessment of the prevalence of sexual and gender-based violence (SGBV) among Burundi refugee women in Tanzania showed 27% of randomly selected women 12-49 years old had been raped since becoming refugees. A multi-sectoral SGBV programme involving several NGOs, UN agencies, Tanzanian Government staff (police, ministries,) and the refugee community was implemented. Main sectors involved in the programme were protection, community support, security and health.

The objective of the health programme, implemented in conjunction with other sectoral programmes, was to provide appropriate health examination and treatment to prevent unwanted pregnancy. One major step was the establishment of a 24-hour drop-in centre staffed by refugee women, located in the maternity wing of the camp medical facility. The centre offers a confidential, safe and friendly environment to encourage women to attend. Because the centre offers a wide range of services as well as addressing sexual violence, survivors are not automatically stigmatised for seeking assistance.

Other steps included the training of community health and medical workers to treat survivors in line with guiding principles of confidentiality, respect, security and safety. Health care centres also provide medical examination and treatment, along with medical documentation required for legal proceedings.

Sources:

Monitoring and Evaluation of Sexual Gender Violence Programmes, Kigoma and Ngara, Tanzania, April 2000 (UNHCR)

Pain Too Deep for Tears (IRC) http://www.intrescom.org/pdf/sgbv_1.pdf

Sexual Health Exchange (2000/2)



FOCUS ON REPRODUCTIVE HEALTH

Reproductive health: adolescents

In refugees or refugee-like settings, reproductive health services established should take into account the special needs of adolescents. Background characteristics of young people including their religion, cultural upbringing, urban or rural origins and level of education will all define their needs. Some basic reproductive health needs of adolescents include:

- √ Information on sexuality and reproductive health;
- √ Access to family planning services;
- √ Prenatal and post-abortion care;
- √ Treatment of unsafe abortions;
- √ Diagnosis and treatment of STIs;
- √ Protection from sexual abuse; and
- √ Culturally appropriate psychological counselling and mental health services.

For young people living as refugees, the normal stresses and challenges of adolescence are much greater. The transition to adulthood is often made more difficult by the absence of the usual role models and the breakdown of the social and cultural system in which they live.

Taken from: Reproductive Health in Refugee Situations, An Inter-Agency Field Manual available online at: http://www.who.int/reproductive-health/publications/interagency_manual_on_RH_in_refugee_situations/index.en.htm

Male reproductive health

In recent years, many family planning and other reproductive health programs have successfully integrated men and reproductive health (which is sometimes called “male involvement” or “men as partners”) into programmes.

These programs recognise that men have an important influence on women’s and children’s health and also have distinct reproductive health needs of their own. In many settings, men also may serve as gatekeepers to women’s access to reproductive health services. Research and program experience are demonstrating that many men care about and are willing to make positive contributions to the reproductive health of their partners and well-being of their families. Despite the surge of interest in this area, there is a lack of consensus about what it means to involve men in reproductive health programs and uncertainty about how such involvement will affect women’s health and status.

One of the main challenges for reproductive health programmes integrating men is to design and implement these programmes in a way that doesn’t undermine men’s views of themselves and their roles in society. In many refugee and refugee-like situations, men cannot fulfil their traditional roles and responsibilities; further perceived threats to their roles can lead to a lack of co-operation.

Adapted from: <http://www.rho.org/html/menrh.htm>

Minimum initial service package

The Minimum Initial Service Package (MISP) is a set of activities that should be implemented to respond the reproductive health needs of populations in the early phase of an emergency. The components of the MISP form a minimum requirement and comprehensive services should be provided as soon as the situation allows.

Components of the MISP include the identification of an individual to facilitate co-ordination, the prevention and management of the consequences of sexual violence, the reduction of HIV transmission, the prevention of excess neonatal and maternal mortality and planning for the provision of comprehensive reproductive health services.

Crucial elements of care

Angola: In-depth operational research into the care and services available to women from the time they become pregnant through delivery and postnatal care is due to start in the next few months.

Funded and supported by WHO, the research will be done by the Ministry of Health under the leadership of Dr Adelaide de Carvalho, director of national public health. It will provide essential information on which to base action to reduce what is estimated to be one of the highest rates of maternal mortality in the world.

“We know it is tied up with destruction of health infrastructure, movement of people, lack of appropriate supplies and equipment and the level and motivation of staff, but what we want to do is pin down clear areas where we can intervene and establish clear practical actions.”

It is anticipated the study will also reveal specific in-service training needs. Currently there is no formal system of continuing education in Angola and most of those who attend women prenatally or in delivery are technicians with no specialist training.

Huambo, Bengo, Moxico and Malanje are the sites selected for the research, and preparatory discussions are currently taking place with the local authorities. The project will also link with the Swedish-funded CAOL (Coordenação Atendimento Obstétrico de Luanda) project which is focusing more on institutional services, and with work being done by UNICEF involving maternal death audit

By way of example Dr Oscar Castillo, medical co-ordinator for UNICEF says an analysis of 56 maternal deaths in Huila showed the clinical causes of death to be malaria (50%), haemorrhage (20%), infection (20%), obstruction (15%) and toxemia (15%). But in 65% of these cases greater use and availability of antenatal services, more rapid referral to hospital and better management and treatment once there could have saved lives. In principle, adds Dr Castillo, “all maternal deaths are preventable”.

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HIV/AIDS

The prevention and treatment of STIs, a reduction in transmission of HIV/AIDS infections and care for those affected by AIDS are integral objectives of reproductive health programmes in emergencies. A number of steps to ensure the establishment of effective services are set out in the Inter—Agency Field guide and are summarised here.

A first step is to perform a situational analysis, incorporating information on prevalences of STIs and HIV in the home and host countries along with location of specific risk groups in the refugee community and an understanding of cultural and religious beliefs and attitudes concerning sexuality reproductive health and STIs and AIDS.

Programmes should next be designed and implemented based on the situational analysis but basic elements of response include:

- √ Universal precautions in health care settings;
- √ Safe blood transfusion;
- √ Access to condoms;
- √ Access to STI care;
- √ Information education and communication activities; and
- √ Comprehensive care for people with HIV/AIDS.

Data on the number of STIs and HIV/AIDS cases presenting for treatment should be monitored. Although underreporting of cases should always be taken into account, indicators can be used to ascertain trends and for planning services.

Some of the challenges in implementing HIV/AIDS programmes in refugee and refugee-like situations include finding adequately trained personnel and functioning facilities within which to work.

Full details can be found in *Reproductive Health in Refugee Situations, An Inter-Agency Field Manual*. The Manual is available online at: http://www.who.int/reproductive-health/publications/interagency_manual_on_RH_in_refugee_situations/index.en.htm

«Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning, prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; (and) prevention of unwanted and high-risk pregnancies...»

— Programme of Action, International Conference on Population and Development, 1994.

Further information on HIV/AIDS in Complex Emergencies can be found in Issue 7 of Health in Emergencies available at www.who.int/eha/disasters, then click Newsletters at the bottom of the screen.

Mobile clinics for quake victims

India: Mobile clinics - which are part of the United Nation's Population Fund (UNFPA) integrated population and development programmes - were refocused in Gujarat State after the earthquake in January 2001 to help earthquake victims, with a particular focus on pregnant women and newborn babies. The clinics provided reproductive health care, including HIV prevention, and help to ensure safe deliveries.

Following a rapid needs assessment, identifying health sector needs in the entire state, UNFPA dispatched emergency

resources and additional personnel. The projects covered the five districts of Surendranagar, Kutch, Banaskantha, Sabarkantha and Dahod.

Three of the five districts were severely affected by the earthquake, which has resulted in the collapse of the district health system in Kutch, and severe damage in Surendranagar and Banaskantha Districts.

UNFPA works with governments, the United Nations system, and non-governmental organizations to provide quality reproductive health care and prevent the spread of sexually transmitted diseases, including HIV/AIDS, in conflict and disaster situations. The Fund also provides educational materials and training for health care professionals to build local capacity and strengthen current development efforts.

Further information can be found at: <http://www.unfpa.org/news/pressroom/2001/indiaquake.htm> or by contacting P DeLargy (delargy@unfpa.org), J Jensen (jensen@unfpa.org) or C Shanahan (shanahan@unfpa.org)

Some resources:

Gender and Humanitarian Assistance Resource Kit (CDRom)

Inter-Agency Standing Committee

This CDRom provides guidance to ensure a gender perspective is fully integrated into humanitarian activities and policies. For more information, contact Gretchen Bloom, WFP at gretchen.bloom@wfp.org or Kirsi Madi, UNICEF at kmadi@unicef.org

Reproductive Health Kit (CDRom), UNFPA

This multilingual description of the Reproductive Health Kit is available upon request to:

United Nation's Population Fund
Emergency Relief Office
9, chemin des Anémones
1219 Geneva SWITZERLAND

Reproductive Health in Refugee Situation, An Inter-Agency Field Manual Available online at: http://www.who.int/reproductive-health/publications/interagency_manual_on_RH_in_refugee_situations/index.en.htm



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Safe motherhood

Most maternal deaths are the result of haemorrhage, complications of unsafe abortion, pregnancy-induced hypertension, sepsis and obstructed labour. A number of factors increase the risk of maternal mortality in refugee settings. During the exodus and emergency phase of a complex emergency pregnant women may become malnourished and anaemic and are therefore at higher risk of infectious diseases. They are exposed to physical and psychological violence. They are often alone and may have to give birth under hazardous conditions.

Safe Motherhood programmes should be designed to reduce death and illnesses resulting from complications of pregnancy and childbirth and should include:

- √ antenatal care with the objective of establishing contact with the women and identifying potentially high-risk pregnancies;
- √ delivery care to ensure a safe clean delivery and get skilled help in a timely fashion for complicated deliveries; and
- √ post-natal support which would include care of the baby and breastfeeding support.

Adequately functioning facilities are a major challenge to implementing many safe motherhood programmes in emergency settings.

Full details can be found in *Reproductive Health in Refugee Situations, An Inter-Agency Field Manual*, available online at: http://www.who.int/reproductive-health/publications/interagency_manual_on_RH_in_refugee_situations/index.en.htm

Some useful websites:

United Nations Population Fund
<http://www.unfpa.org/tpd/emergencies/index.htm>

Global Reproductive Health Forum
<http://www.hsph.harvard.edu/Organizations/healthnet/>

US Centers for Disease Control and Prevention (CDC)
<http://www.cdc.gov/nccdphp/drh/>
http://www.cdc.gov/nccdphp/drh/mrh_mens.htm

The Women's Commission
<http://www.womenscommission.org>

Reproductive Health Outlook
<http://www.rho.org/index.html>
<http://www.rho.org/html/menrh.htm>

Marie Stopes
<http://www.mariestopes.org.uk/>

UN High Commissioner for Refugees
<http://www.unhcr.ch/issues/women/women.htm>

World Health Organization
<http://www.who.int/rhr>

Reducing maternal mortality

Sierra Leone: A nationally representative survey, which was carried out in Sierra Leone at the end of 2000, suggests that the maternal mortality rate - at 1,800/100,000 live births estimated to be one of the highest in the world - might be reduced by improved training of traditional birth attendants and increasing the level of women's education.

Quality prenatal care can contribute to the prevention of maternal mortality through early detection and management potential risk factors. 68% of the women who gave birth in the year prior to the survey were seen at least once for antenatal care. 42% who gave birth in the last year were attended by a skilled professional - either a physician, nurse, midwife or auxiliary midwife.

However, a large proportion of women were attended by a traditional birth attendant (TBA) for delivery. Only 3% were attended by physicians which suggests that very few women deliver at hospitals where comprehensive services are available. Since maternal deaths are often the result of mismanagement of complicated deliveries, TBAs need to be trained to recognise high risk pregnancies and complications during childbirth for quick referrals.

58% of those who gave birth in the year prior to the survey received sufficient doses of tetanus toxoid to protect their children against neonatal tetanus. The results of this survey suggest that women with a secondary or higher level of education are more likely to understand and comply with these measures.

Use of contraception among women of reproductive age was very low at 4.3%¹ and women's level of education was strongly associated with the use of contraceptives.

The majority of women aged 15-49 in Sierra Leone have either never heard of HIV/AIDS or have insufficient knowledge about the disease. For example, while 34% of women interviewed knew that mother-to-child transmission is possible, only 21% knew three ways to prevent transmission. Women's education was strongly associated with accurate knowledge about HIV/AIDS.

The survey included modules on a number of topics, many of which contained information related to reproductive health of women. Information in the report is considered to accurately represent the situation in Sierra Leone.

Sources:

Status of Women and Children in Sierra Leone at the End of the Decade

Household Survey Report undertaken by the Government of Sierra Leone, November 2000

http://www.childinfo.org/MICS2/natlMIC3repz/Sierra_Leone/MICS2F-1.pdf

¹ (# of married or 'in union women' aged 15-49 years who report that they or their partner are using a contraceptive method)/(#women aged 15-49 years in the sample)

FOCUS ON REPRODUCTIVE HEALTH

Airlift to safeguard reproductive health

El Salvador: Supplies to ensure safe childbirth and prevent the spread of HIV/AIDS and other sexually transmitted diseases were airlifted to those displaced by the earthquake in El Salvador in January 2001 by UNFPA. The supplies, including medical equipment needed to resuscitate newborn babies and treat miscarriages and complicated pregnancies, were intended to cover the urgent reproductive health needs of a population of 300,000 for a period of up to three months.

“Pregnant women and newborn babies are the most vulnerable groups in a natural disaster,” said the Executive Director of UNFPA, Thoraya Obaid. “Complicated pregnancies and deliveries are common in high-stress environments and can become life-threatening if left untreated, as can miscarriages. Quality prenatal care and safe deliveries are essential to ensure safe motherhood and healthy children, and that need is currently not being met in many areas of El Salvador. UNFPA is rushing to change that.”

“Quality prenatal care and safe deliveries are essential to ensure safe motherhood and healthy children...”

The safe motherhood and reproductive health supplies provide basic equipment and materials needed to perform clean, safe deliveries. They include clean home delivery supplies, such as plastic sheeting, razor blades for cutting umbilical cords, sterile gloves and plastic aprons. Also included are health centre delivery equipment used to stabilize precarious situations, such as convulsions and bleeding; and referral-level instruments to perform caesarian sections, resuscitate babies and mothers, as well as to handle childbirth complications. The supplies also include tools for HIV prevention and safe blood transfusion.

Further information can be found at: <http://www.unfpa.org/news/pressroom/2001/elsalquake.htm> or by contacting P DeLargy (delargy@unfpa.org), J Jensen (jensen@unfpa.org) or C Shanahan (shanahan@unfpa.org)

Human rights, reproductive health

Human rights related to reproductive health include:

- √ The right to life and health;
- √ The freedom to marry and determine the number, timing and spacing of children;
- √ The right to access information;
- √ The right to non-discrimination and equality for men and women;
- √ The right to liberty and security of the person, including freedom from sexual violence and coercion; and
- √ The right to privacy.

Source: *Universal Declaration of Human Rights* (<http://www.unhcr.ch/udhr/index.htm>)

The United Nations Population Fund (UNFPA) Humanitarian Response Group works with governments, the United Nations system, and non-governmental organizations to provide quality reproductive health care and prevent the spread of sexually transmitted diseases, including HIV/AIDS, in conflict and disaster situations. The Fund also provides educational materials and training for health care professionals to build local capacity and strengthen current development efforts.

UNFPA is the world’s largest multilateral source of population assistance. About a quarter of all population assistance from donor nations to developing countries is channelled through the Fund. Since it began operations in 1969, the Fund has provided about \$5 billion in assistance to virtually all developing countries.

<http://www.unfpa.org/tpd/emergencies/index.htm>

Training is not enough

Ingushetia, Chechnya: A recent training course providing information on antenatal care, family planning, obstetric care and sexually transmitted infections (STI) is likely to have a limited impact due to lack of access to services and limited supplies and materials.

The training, which included 132 professionals in the field of reproductive health, was organised based on recommendations of an assessment in June 2000 by UNFPA and WHO. The June assessment reported maternal mortality rate of 100/100,000 live births and a perinatal mortality rate of 51/1,000. Both these numbers indicated a need to improve reproductive health services provided.

Antenatal care in the area is reportedly low at 20%, due to a lack of accessibility and low quality of service. IDPs tend to make less use of antenatal care than the local population. All pregnant women are screened for syphilis and HIV/AIDS on a mandatory basis but counselling is not provided. Moreover, women often leave the hospital before lab results are available, as hospitals do not have all the necessary reagents in stock. However, very few STI cases are reported.

Family planning is not well developed. And despite the fact that UNFPA has provided free contraceptives, nothing is available in the field; women are advised to purchase their contraception. This is problematic because although women are reportedly willing to use contraception they do not know where to go to receive support. Moreover, there is very little educational material and none of it is distributed cost-free to interested parties.

Adapted from:
Improving Women’s and Children’s Health in Ingushetia, WHO, March 2001. Full report available at: <http://par.who.dk/EventPath/North%20Caucasus/PHC%20issues%20Inghushie.pdf>



WORLD HEALTH NEWS

How to get DOTS back on track?

Angola: The Ministry of Health, supported by WHO, is this year trying to rejuvenate a TB programme that has been fighting a losing battle over recent years due to an environment that is almost the completely opposite of conditions needed for effective treatment.

TB is the second most important cause of mortality in Angola. Over 15,000 cases were reported in 1999, a figure thought to be well surpassed in 2001, but at present treatment is available for around 1500 patients. DOTS (Directly Observed Treatment Short-course) was introduced in 1998 but is achieving cure rates of less than 40 per cent where it has been implemented.

“It is very hard to imagine that many of the centres which should, and would like, to implement DOTS have not been able to do it until now because of the difficulty of following patients and maintaining good supplies of drugs,” says WHO officer Dr Sebastian Nkunku.

While population movement is one challenge, maintaining free drug supply is another major problem to be overcome. In Cuito Hospital, the sanatorium manager says patients receive free drugs, but low supplies leave dozens waiting for treatment. Lack of streptomycin this month, he adds, has prevented between 15 and 25 children from starting treatment.

For further information, please contact Dr Pier Paolo Balladelli at whoang@ebonet.net or Hilary Bower at bower@who.int

Diagnosis good, treatment poor

Iraq: Thirteen water quality laboratories in the Northern Governorates are now open and functioning thanks to renovations carried out by WHO under the SCR 986 programme. But water quality remains poor. Recent bacteriological tests show urban water sources fall within WHO guidelines, except for Erbil and the other two governorates’ semi-urban and rural areas.

The monitoring system across both urban and rural areas works through five central laboratories in the governorate headquarter towns and eight basic testing satellites which have all been equipped since 1998. In the past year, WHO has also led 15 workshops for local health authority staff covering techniques of investigation, sampling, data analysis and public health issues.

Rented vehicles allow staff to make daily random visits throughout the governorate to examine water sources, storage tanks and water delivery networks, take samples for analysis and carry out chlorination. They also work to raise community awareness of safe water practices and, together with WHO consultants, co-ordinate emergency response to outbreaks of water-borne epidemic diseases.

For further information, please contact Dr S Ben Yahmed at benyahmeds@who.int or Dr P Piva at pivap@who.int

PAHO’s Newsletter **Disasters: Preparedness and Mitigation in the Americas** is now available in pdf format at <http://www.paho.org/disasters/> then click on Newsletter.

Please forward comments and requests to disaster-newsletter@paho.org

Healthy ageing in emergencies

Complex emergencies, and to a lesser degree societal crises with increased level of intolerance and violence, interfere with the processes of healthy ageing, underscores The World Health Organization (WHO). Older persons are made more vulnerable in complex emergencies by their increased dependence on family, community and/or institutional caring capacities and lifeline systems - all likely to be disrupted in a complex emergency.

WHO, through its Department of Noncommunicable Disease Prevention and Health Promotion (NPH), and the Ageing and Life Course (ALC) Unit, is conducting a survey throughout the UN system aimed at identifying specific actions and proposed strategies of different agencies with respect to older persons in humanitarian emergencies. This survey would be incorporated into the work of WHO through NPH/ALC. WHO will be asking concerned agencies to share their views, plans and activities with regard to older people with WHO.

The plight of older persons in emergency situations has only recently received the attention it deserves. Previously, emergencies were largely confined to countries with a young age-structure – consequently the absolute and relative numbers of older people afflicted were small. Furthermore, figures of refugees and internally displaced persons do not reveal the full extent of the problems faced by older people during emergencies. Often, the elderly are too frail to move from affected areas. Sometimes they have to be left behind while the rest of the family flees, or they simply refuse to move as they would rather die and be buried in ancestral soil.

UNHCR has already developed a policy on older refugees - based on the United Nations Principles for Older Persons - to ensure that the unique needs of older refugees are acknowledged and reflected in UNHCR protection and programming initiatives and that older refugees are recognised as active and contributing members of their communities.

HelpAge International, the leading NGO in this area, has published a report: “Older people in disasters and humanitarian crises – a guideline for best practice” (HAI, 2000), with the support from UNHCR. This document identifies the issues, provide guidelines for action with examples from the field and suggests protocols for further research in order to provide the evidence of the problems through empirical data.

For further information, please contact Dr A Kalache at kalachea@who.int

Peru earthquake response

Peru: The Pan American Health Organization is working closely with authorities in Peru in response to a major earthquake that shook southern Peru and northern Chile, leaving some 70 dead, 1,200 injured, and some 10,000 homeless. The cities of Arequipa, Tacna and Moquegua were most affected by the 7.9 Richter scale earthquake.

PAHO disaster experts from its Ecuador office arrived in Peru and are supporting Ministry of Health and Civil Defense authorities in assessing immediate needs, evaluating damages, and providing health services to affected populations.

A situation room has been set up in the health ministry, with PAHO support, and updates on damages and the health situation are being prepared, Dr. Ugarte said.

“There is no need for medical volunteers or field hospitals”

Though enough supplies are on hand to treat the injured, there is a lack of medicines for acute respiratory infections and diarrhoea, according to Ministry of Health officials.

“There is no need for medical volunteers or field hospitals,” said Dr. Claude de Ville, chief of PAHO’s Emergency Preparedness and Disaster Relief Coordination program in Washington.

Adapted from PAHO Press Release 25 June 2001 (<http://www.paho.org/English/DPI/p010625.htm>). For further information, please contact Mr D Epstein at epsteind@paho.org

EHA’s website provides information on what is happening in emergency situations (health situation reports, epidemiological surveillance, needs assessments etc.) and what to do about it (technical guidance).

<http://www.who.int/eha/disasters/>

Gloomy Response to the CAP

WHO highlighted the need for increased and more evenly distributed funding for the humanitarian packages at the mid-term review of the UN Consolidated Inter-Agency Appeals (CAP), on 22 May 2001. The health sector is, once again, dramatically under-funded.

WHO’s situation is particularly worrying since the Organization has received less than US\$18 million of the US\$68 million for which it has appealed, thus reaching only some 10% funding of its activities.

Coverage of health needs in some critical conflict areas such as Afghanistan, Eritrea and Ethiopia, Somalia, Sudan, the West Africa and Tajikistan, for example, has not even reached 5%.

For further information, please contact Dr Y Tegegn at tegegn@who.int

Repeated crises test WHO

Kosovo: Newly displaced people in Kosovo - mainly as a result of renewed fighting between the Macedonian Security Forces and ethnic Albanian armed groups - are straining the response capacity of WHO Kosovo’s reduced staff.

The WHO humanitarian office in Pristina is responsible for co-ordinating medical care for the approximately 40 000 displaced people, comprised of refugees from the Former Yugoslav Republic of Macedonia (FYROM) and internally displaced people from South Serbia. WHO works with the Department of Health to make sure that medical teams are in place at official and unmarked border crossing points, drugs and equipment are available and free health care is accessible when refugees reach their temporary homes.

Further complicating the situation is an outbreak of Crimean-Congo haemorrhagic fever (CCHF), identified by the communicable disease surveillance system which was set up in collaboration with WHO. As of 11 June 2001, the WHO Office in Pristina had reported 30 suspected cases and 4 deaths between 16 May and 10 June 2001 in the southwestern area of Kosovo.

WHO’s Global Outbreak Alert and Response Network together with WHO staff in Kosovo - until recently focusing on preparedness for refugees - have had to switch to a new priority and assist the Department of Health and Social Welfare of the United Nations Administration of Kosovo and the Institute of Public Health cope with the outbreak. Partners in the Global Outbreak Alert and Response Network are providing assistance with laboratory support and in carrying out initial assessment.

Although there has been important progress in the health sector’s institutional reconstruction and capacity building and the system has coped well with the influx so far, Kosovo’s health care system still has a long way to go before it can stand alone, and if the flow of refugees rises it will come under severe strain. So will the ability of WHO Kosovo to provide support. Funding has fallen sharply this year and WHO Kosovo has faced difficult decisions as it is forced to cut its staff by a third and the scope of its operations.

The “emergency phase” is officially over, Kosovo has moved into development. But in the health sector, emergency is still an everyday word. Any new day can deliver an unexpected crisis that will divert the remaining core staff away from their programmes and planned activities. If a similar combination of crises occurs again and lack of funds will continue within a few months, WHO Kosovo is unlikely to be able to provide all the support expected of it.

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For further information on the South Balkans, visit the following websites:

<http://par.who.dk> and
<http://www.who.int/eha/disasters>



WORLD HEALTH NEWS

Health library for disasters

The Global Virtual Library of Essential Information Resources on Public Health for Disasters and Complex Emergencies

Thanks to grant from DFID, several agencies - WHO, UNHCR, UNICEF, ICRC and the SPHERE project - have merged their technical expertise into one CDROM that contains more than 250 publications dealing with disaster reduction and best public health practices related to humanitarian assistance.

This electronic library, comprised of technical and scientific disaster information resources which have been selected for technical value and quality, will also be accessed on the Internet. Thus, this knowledge can be transferred and made available to millions of users free of charge.

One of WHO's strategic goals is to facilitate the dialogue between national and international public health actors on the basis of internationally accepted guidelines. To promote just such exchange, we are using state-of-the-art electronic information technology to contribute to make available the most complete and up-to-date material possible. This first CD-ROM opens a process which will be evaluated, replicated and updated in the future.

Summaries of the contents of CDROM can be accessed at the web addresses: <http://www.who.int/eha/disasters/> and at <http://www.paho.org/disasters/>. WHO is currently looking into how to ensure the widest dissemination of this product. Interested organisations are advised to contact WHO at the email addresses below for further details.

For further details or to request copies of the CDROM, please contact WHO/EHA at: eha@who.ch. or PAHO/PED at disaster-publications@paho.org

Health centres activated

Herat, Afghanistan: Following a recent assessment mission to Herat, in western Afghanistan, WHO intends to activate 27 basic health centres at district level to ensure training, logistics support, essential drugs and minimal referral services. The aim is to provide essential health services to the 'not yet displaced' in rural areas and improve delivery of care for major childhood diseases. The technical skills of provincial and regional health workers will be upgraded, specifically case management of acute respiratory infections and diarrhoea, the two major killers of children under five.

Intensified health education campaigns will be conducted to improve knowledge on how to provide home care to a sick child. Meanwhile, WHO is providing ongoing assistance to the IDPs in the region by distributing essential supplies to the camp clinics and to the clinics of the Ministry of Public Health. The workload of the local health care delivery system in Herat city is estimated to have risen by around 60% since October 2000.

For further information, please contact Dr K Shibib at shibibk@who.int

Mapping disasters in WPRO

EHA/WPRO and the Asian Disaster Reduction Center (ADRC) are working together to geographically depict patterns of natural disasters in WHO's Western Pacific Region since 1980. Using GIS software combined with data from Université Catholique de Louvain's Centre for Research on the Epidemiology of Disasters (CRED), ADRC database, the United States Geographic Services and the National Land Agency in Japan, the maps produced by the project will provide an 'at a glance' view of high-risk areas within a country.

In addition, this will identify gaps between the information which has been collected by CRED system and the information which should be collected for national capacity building for emergency management is one of other objectives. Sample maps have already been prepared for Papua New Guinea, Philippines and Viet Nam using WHO HealthMapper.

*For further information, please contact Mr Y Takashima at takashimay@wpro.who.int
Visit ADRC's website at <http://www.adrc.or.jp/top.asp>*

Fight to eradicate polio continues

South Sudan: The Polio program of south Sudan has completed its third round of NID's for 2001. Data on the number of children immunized is being compiled and results will be made public soon. This is the fourth year that immunization campaigns have been carried out in southern Sudan. Planning is already beginning for a more targeted immunization campaign in October and November to improve coverage in hard to reach areas and high-risk border areas where poliovirus might enter south Sudan from neighbouring countries.

AFP surveillance activities continued in April. So far in 2001, 8 cases of Acute Flaccid Paralysis (AFP) have been identified and investigated. While AFP surveillance improved significantly last year, efforts will be redoubled in 2001 to identify and investigate more cases of AFP. In addition, there will be a major emphasis on trying to identify cases of AFP earlier, within 14 days after the onset of paralysis.

"One of the major performance criteria for certification is attaining a target of 80% of cases investigated within 14 days of onset of paralysis."

As part of the effort to make further improvements in AFP surveillance, all polio field staff will be going through refresher training in their localities over the next several months. Local health department staff and NGO staff will also be invited to attend these training sessions. Additional two experts from the US Centers for Disease Control and Prevention (CDC) will also strengthen the surveillance team.

For further information, please contact Dr R Shoo at rumishael.shoo@unsom.unon.org

Stress management in disasters

It is widely recognized that emergencies and disasters are great stressors, not only for the affected population but also for those charged with providing a response. Elevated stress levels reduce response capacity and put physical and mental health at risk. Unfortunately, most Latin American and Caribbean countries have no specific control programmes in place to deal with stress-related issues in disaster situations.

To address this gap, in 1998 PAHO/WHO brought experts together and created the Caribbean SMID Program (Stress Management in Disasters). Although the SMID program was originally created to prevent and mitigate psychosocial problems among disaster response personnel, the methodology can be easily adapted and applied to the community at large, including children and adolescents.

The two new publications on this topic are entitled "Stress Management in Disasters" and "Insights into the Concept of Stress". These practical texts can be used to prepare courses on the topic and offer guidance to help those who provide post-disaster mental health assistance.

Download the full text of these publications from www.paho.org/disasters/ or request a copy from disaster-newsletter@paho.org

Logistics of emergency relief

WHO, together with several partner organisations, is planning a series of activities in the area of logistics support and supply management with the overall aim of improving the management of relief supplies in emergency response by ensuring that international aid agencies use global information logistics systems.

The first of these activities is a workshop to discuss systems for the management of relief supplies in emergencies, organised by WHO/PAHO, WFP and OCHA and to be held in July 2001. Several humanitarian agencies have developed logistics systems for the vertical control and tracking of their own relief supplies. This workshop will bring together interested parties to compare existing systems and learn from the distinct initiatives. The meeting will discuss the usefulness and feasibility of a global information system for the management of emergency relief supplies. This system, which could incorporate the combined lessons learned by the international community, could provide a tool for coordination, information exchange, transparency, and commodity tracking to meet the needs of those responsible for disaster response at national levels, as well as those of UN agencies and NGOs.

The second planned activity is a 'training of trainers' course on the Supplies Management System (SUMA) organised jointly by WHO/PAHO and the Italian Government and planned for the second trimester of 2001. The goal of this course will be to train attendees as SUMA instructors, to increase response capacity of European NGOs involved in humanitarian action and to ensure the sustainability of the SUMA methodology.

For further information, please contact Dr S Yactayo at yactayos@who.int.

Stress management teams

The Caribbean is moving to establish national Stress Management in Disasters (SMID) teams, as part of PAHO's Stress Management in Disasters programme. This initiative began in 1998 to prevent and mitigate psychological stress that many emergency response personnel undergo during traumatic situations like disasters. Under the programme, SMID manuals have been developed and to date, more than 250 persons in nine countries trained. SMID training provides knowledge and skills to understand, recognize and manage stress responses to traumatic situations. Training includes the establishment of SMID teams. Starting this year, emphasis is being placed on establishment of national SMID teams as part of the disaster management arrangements. Saint Lucia, for example, has already developed its own team protocols and Standard Operating Procedures. Barbados, Curacao and Trinidad and Tobago are also pursuing similar developments. This ongoing initiative and is planned to be expanded to other countries.

For further information please contact Dr. D van Alphen at vanalphd@cpc.paho.org

Health in the North Caucasus
newsletter is available on line:

<http://par.who.dk/default.asp?PageID=1&EventID=1>

Reducing strain on water supplies

Ingushetia: Water production in Ingushetia was insufficient even before the arrival of 200,000 Chechens into Ingushetia in late 1999, increasing the population by more than 50%. To alleviate the situation, the established republic-wide water system is being improved and emergency water supplies are being provided at 270 individual IDP locations.

Although Ingushetia has a source of good quality underground water, the production rate was insufficient to supply the expanded population. The central water supply company, Vodokanal, had been able to deliver less than 40% of the normal supply. In some urban areas there is no reticulated supply, whilst where reticulation exists, there is running water for only a few hours of the day.

UNHCR is working to improve the rate of water extraction from the central underground source, and to improve the capacity of the system to transfer water from the source to the extremities of the system.

At the same time, emergency water/sanitation services to camps and spontaneous settlements are being carried out by UNHCR through its implementing partner, International Rescue Committee (IRC), and by several other agencies including ICRC, Islamic Relief and government agencies.

In addition to water supply activities, a public health education programme with emphasis on domestic and personal hygiene, and food preparation is ongoing.

Extracted from: 'UNHCR Water/Sanitation Programmes in the North Caucasus' by Ray Coughran. The full article is available at: <http://par.who.dk/EventPath/North%20Caucasus/Newsletter05-2001.pdf>



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