Anatomy of a complex emergency
Notes from the field
SEARHEF: Making a difference with speedy assistance
All too often, we hear of communities and countries torn apart by war and strife. The abject misery of thousands of innocent people caught in a web of violent conflict, with life as they knew it suddenly shattered, is beamed almost daily into our living rooms. The very diversity of language, religion, and ethnicity which, woven together, make our cultures so uniquely rich and beautiful, are the same threads that pull people apart and lead them into a vortex of devastating violence and hatred that can sometimes last for generations, hampering development or even sending it into reverse.

In the WHO South-East Asia Region we have experienced our share of such complex emergencies. In May this year, the Sri Lankan conflict between the government forces and the Liberation Tigers of Tamil Eelam (LTTE) separatist group came to an end after 25 years. Nepal is now going through a transition phase after the ten-year Maoist insurgency ended with a Peace Agreement in 2006. Timor-Leste and Aceh, Indonesia, are also emerging from long periods of conflict.

Such emergencies impact health deeply and negatively. Disease and death are ruthlessly impartial, striking warring factions with equal ferocity. Violence exacerbates this situation, as health facilities are destroyed, health services disrupted, roads are blocked, medical supplies
become unavailable, and health workers themselves fall victim or flee the area in large numbers. With such basic services missing, the most vulnerable people — women, children, the elderly — are more likely to die from preventable diseases or childbirth complications than from injuries. It’s not surprising that seven of the ten countries worldwide with the highest child mortality rates have all experienced recent conflict. Living in daily fear and uncertainty, sometimes for years, also has long-term mental health consequences.

There is the proverbial silver lining in this bleak scenario. The very fact that health is an area of common concern for both parties can be used to bring the warring factions together. This concept of “Health as a Bridge for Peace” first emerged in 1984, when the Pan American Health Organization (PAHO) successfully launched immunization campaigns that compelled both guerilla and government forces in Central America to collaborate. It has since been successfully implemented in many areas of the world. In Aceh, Indonesia, it has made a difference to the health system, as you will read in this issue.

At WHO, we see our role as minimizing, as best we can, with all the tools at our disposal, the health impact of the humanitarian crises arising from complex emergencies. In this issue of Focus, we present you all the challenges to health that complex emergencies pose; our experiences with such emergencies in different SEA Region countries; and the dedication of the health workers on the ground who continue their work against all the odds.

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This article dissects a complex emergency, focusing on its impact on health. First, a few clarifications are needed: What is a complex emergency?

The official definition of a complex emergency by the UN Inter-Agency Standing Committee is “a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single agency and/or the ongoing United Nations country program.”

1 UN Inter-Agency Standing Committee 1994
Such "complex emergencies" are typically characterized by:

- Extensive violence and loss of life; massive displacements of people; widespread damage to societies and economies.
- The need for large-scale, multifaceted humanitarian assistance.
- The hindrance or prevention of humanitarian assistance by political and military constraints.
- Significant security risks for humanitarian relief workers in some areas.

Wars and conflicts have been the main causes of complex emergencies. But the public health issues have often been neglected. These complex emergencies cause displacement of people, whether in the millions or a few thousand; and destruction of homes and critical infrastructure such as schools, roads, bridges, water sources, and most of all, hospitals and clinics. Wars, in a wave of destruction, leave the population without access to essential services that provide for health – for life.

In the South-East Asia Region countries have a variety of experiences with conflict. Some countries are either affected by a war situation/civil conflict (Sri Lanka) or have just emerged from it (Timor-Leste, Indonesia’s Aceh Province, Nepal) or could be facing some sort of localized violent conflict within specific areas (India, Thailand).
What are the health impacts of such an emergency?

On the health information base
- This is generally weak and fragmented. Information systems are badly affected and sometimes collapse; their coverage is invariably reduced.
- Communication and access to troubled areas are difficult, data are outdated and incomplete, standardization is poor, and the collection and analysis of data clash with other priorities.

However, in cases where data are available, they are scattered and their accuracy difficult to check. Further, the capacity to compile them and make sense of them in a comprehensive way is absent. This is because of lack of coordination among organizations working in this area, overcrowding of autonomous players, communication and security constraints and fast-evolving environments, which leave little time for sharing and analysis of information. This leads to a loss of institutional memory.

On the health services
- Conflicts have also made it difficult for health facilities to cope with a sudden influx of injured people. In these situations, the problem is usually not the

3The resulting reduction of coverage is often different in various areas for different reasons.
physical or structural integrity of a hospital or a clinic, but understaffing and lack of access to supplies and essential utilities. However, the destruction of hospitals and clinics has been witnessed more and more in recent conflicts.

- Security issues prevent staff from applying to or accepting an assignment in conflict zones; where health staff is present, security problems often prevent them from performing their work efficiently.

- Besides hampering the functionality of health facilities, the impact of long, drawn-out conflicts can also be devastating where destroyed facilities have to be rebuilt.

After years of unrest, the violence of 1999 in Timor-Leste caused the destruction of 78% of health facilities. Only around 22% of buildings escaped without major damage, including, fortuitously, the referral hospitals in Dili (the capital) and the district of Baucau. Virtually all equipment and supplies had been looted or damaged beyond use.

In Sri Lanka, health services for those displaced in the recently concluded conflict in 2009 need massive scaling up.

**On the public health needs**

As with any emergency there are several critical basic public health needs that always arise:

- **Water and sanitation**
  
  In the area where a conflict has occurred, most if not all of the water and sanitation infrastructure is destroyed. Moreover, the displacement of people often brings them to areas without such services, or in some cases such services as are provided are not enough.

- **Psychosocial and mental health**
  
  The emotional trauma of a conflict (or any disaster) and the consequences it brings about are always underestimated. Support for people who have been displaced, suffered loss of loved ones, and had their lives disrupted needs urgent attention. Several interventions can be done, mostly through the help of the affected community itself.

- **Communicable diseases**
  
  If the population is moved to a location such as a camp and water and sanitation infrastructure are not adequate, the overcrowding and lack of hygiene and other

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Waste disposal facilities creates an environment where communicable diseases can spread fast. So an improved surveillance system, prepared health facilities and the necessary supplies to handle the potential increase in cases need to be in place.

Other diseases, especially noncommunicable diseases (NCDs), need to be attended to as well, depending on the health profile of the displaced. In the conflict in Kosovo in the 1990s many of the displaced were elderly who had chronic diseases such as diabetes and hypertension. The essential medicines needed were to address these pre-existing conditions.

Reproductive health services also require attention. Depending on the profile of the population, the minimum initial service package (MISP) for reproductive health needs to be in place and expanded depending on the evolution of the emergency.

Most important of all, if the displacement has happened within the country or refugees and asylum seekers have crossed the borders of a country, host countries in many cases bear the burden of those public health needs mentioned above. Policies for such situations need to be in place to address this issue.

What can be done?

There is no prescribed recipe for what needs to be done, for every situation is uniquely defined by political issues around the event; the duration of the event; resources available; health status of the population before the complex emergency; capacity of the health system and the health workforce before and during the emergency; and several other factors.

However, the basics remain the same: strengthened surveillance and early warning for communicable diseases and nutrition, water and sanitation supplies and facilities – provision of soap and buckets can prevent diarrhoea, hepatitis A and a host of other diseases. A culturally sensitive psychosocial support programme also goes a long way (see boxes).

In addition to the interventions mentioned, an overarching need will be coordination, without which

- health services may be duplicated in one area and absent in another
- information will not be accurate or shared or the surveillance will be weak
• health staff time will be wasted
• needs will not be accurately assessed and therefore not adequately addressed

In summary, without coordination, gaps remain unplugged and the health of a whole population can deteriorate.

In 2008, the World Disasters Report\(^5\) stated that there are an estimated 13.5 million refugees and asylum seekers globally. Of these, 1 158 300 are from our Region. This Region has an estimated 1.8 million internally displaced persons, while the global total is 23.2 million.

A brief overview such as this can only just introduce the dense topic of complex emergencies. But hopefully this will help us think about what is needed for the health of people when we see images of those displaced by the cruelty of war and conflict.

“\(\text{The biggest challenge [of working for OCHA in the field]}\) is to ensure a coordinated response to a complex emergency. This is an immense task, regardless of the size of the emergency, because of the number of different types of actors, including governments, rebel groups, donors, UN missions, UN agencies and NGOs. The often-high number of actors within each group complicates coordination further. (A government, for example, might have several ministries, coordination offices, focal points, and the like, causing the government itself to have different policies and strategies on how to approach an issue). This situation can be further complicated by competing interests between different groups, and in particular amongst actors within groups. The World Bank, for example, might call on a government to increase taxes while UN agencies and NGOs are clamoring for the importation of their goods and salaries for local staff to be exempt. Within a particular group, UN agencies for example, turf battles and animosities can be a real thorn in getting UN agencies to agree to consolidated policies, strategies, and programs. So, for a small OCHA office to facilitate coordination is a daunting (but extremely exciting and challenging) task.”

OCHA Official, Angola 1993/95

\(^5\) World Disasters Report 2009 IFRC
Few people are as vulnerable as those caught up in the midst of a complex emergency, such as civil war. If such a situation goes on for years, it is probable that health systems in those areas will be disrupted, and access to food, water and sanitation is likely to be limited and irregular. Large numbers of the population are likely to be displaced and living in IDP camps. In such circumstances effective disease surveillance is crucial to track and treat diseases before they spread and claim more lives in an already vulnerable population. However, setting up effective surveillance in such situations can be challenging.

The first step is to conduct a rapid risk assessment along with national counterparts, in order to define which will be the priority diseases to be put under surveillance. This will depend on the kind of crisis (e.g. cyclones, earthquakes, tsunami, floods, civil wars) and the results of the rapid risk assessment.
Once the priority diseases are identified, it is important to coordinate the work of all agencies working in the front line on health, especially NGOs. In the past, lack of coordination among the various organizations has led to confusion and a less effective surveillance system. Today it is easier because, according to the UN Humanitarian Reforms, WHO is recognized as the lead in the Health Cluster, which includes all international NGOs working in the emergency in health, and involves coordinating their efforts.

From among the health organizations, a working group then needs to be formed for early warning and response (EWAR). This group works on the technical details: list of health events, case definitions, thresholds, reporting units, mode of reporting, analysis and weekly bulletin production and specified timeliness. The EWAR group needs to identify reference laboratories and set up specimen collection; identify a Rapid Response Team and train them; and produce a standard protocol to be used by all participants in the system.

If the national authorities are participating in this process together with health partners, a disease intelligence unit should be set up at the Ministry of Public Health. At the same time, an active event management system needs to be created to be able to follow up daily rumours and verify or discount them within 24 hours.

However, this process is not always smooth sailing. In a complex emergency, such information is often considered sensitive by the government, and one needs to convince the Ministry of Health regarding any concerns about disseminating the information, in order to work in coordination with them.

Another challenge is the coordination of participation of front-line health partners. Sometimes some operators in the front line do not believe that the system in place works well, and prefer to work in their own way. Yet for surveillance to be effective, their cooperation is essential. The acceptability of the system is based on the credibility WHO can provide in terms of timeliness and response capacities. Response is a critical component that can only be implemented with close collaboration between the operational centre and the front-line workers.

A reference laboratory linked with pre-existing facilities in the area of the disaster is necessary so that results of tests to establish the presence of a communicable disease are quickly made available. However, this remains one of the most challenging tasks. In most situations, the pre-existing state of national or provincial laboratories is very poor, and thus a strong effort is needed by humanitarian actors to immediate activate whatever entity is identified as the reference laboratory for the surveillance system in place.

Leadership, transparency and participatory activities with all partners are key to the success of the disease surveillance system in complex emergencies. The key element is trust—winning the trust of the health ministry regarding confidentiality of sensitive issues, and building trust among partners in order to work together. Credibility in ensuring planned activities take place with timely results is therefore important, as are on-the-spot training of personnel involved in the front line and continuous monitoring and follow-up in the field.

The challenges may be formidable, but establishing an effective disease surveillance system is essential to ensuring that an already vulnerable, suffering people do not in addition fall prey to preventable diseases.
During any kind of emergency situation, drinking water supply structures and sanitary facilities could be damaged. In such situations, along with food and shelter, safe water and sanitation are the highest priority interventions that need to be addressed to prevent disease and death. The risks of outbreaks of diarrhoea, cholera and other diseases will persist unless the affected families practice good hygiene. This applies to all types of emergencies, from rapid-onset natural disasters to long-term crises caused by a range of complex factors.

The following are some of the water supply, sanitation and hygiene problems that will arise after an emergency:

- Damage to water sources, water storage tanks, water treatment plants, distribution pipelines and tap points for piped water supply systems.
- Damage to handpumps and tube well structures.
- Contamination of wells and water ponds by debris and saline water.
- Damage to sewerage pipelines and sewage treatment plants in urban areas, and destruction of different types of latrines (pour flush, ventilated improved pit (VIP) latrines, simple pit latrines, community latrines) in rural areas.
- Cross-contamination of sewage into drinking water pipelines, wells and other water sources.
- Disruption in water supply, leading to problems with hygiene practices.
Urgent action in relation to water, sanitation and health

The three top priorities are (1) the provision of sufficient quantities of safe water; (2) basic sanitation arrangements; and (3) promotion of good hygiene behaviours.

The first priority is to provide an adequate quantity of water, and to protect water sources from contamination. A minimum of 15 litres per person per day should be provided as soon as possible, though in the immediately post-impact period, it may be necessary to limit treated water to a minimum of 7.5 litres per day per person. During emergencies, people may use an untreated water source for functions such as laundry and bathing. Water-quality improvements can be made over succeeding days or weeks.

Major health risks due to inadequate excreta disposal arise after disasters. Where normal sanitation structures have been damaged or destroyed, it is essential to provide toilet facilities immediately. Following damage to existing systems, or when parts of a city receive large numbers of displaced or homeless people, increased pressure is put on facilities that may already be under strain. A rapid assessment of damage and needs is required to decide what emergency actions to take.

Drinking water and sanitation dangers to human health and vulnerable groups

Infectious disease transmission is the greatest risk after an emergency. The diseases and conditions of ill-health directly associated with water, sanitation and hygiene include infectious diarrhoea (which can indicate cholera, salmonellosis, shigellosis, amoebiasis and a number of other protozoan and viral infections), typhoid and paratyphoid fevers, acute hepatitis A, acute hepatitis E and F, schistosomiasis, trachoma, intestinal helminth infections (including ascariasis, trichuriasis and hookworm infection), dracunculiasis, scabies, dengue, leptospirosis, etc). The spread of most of these diseases becomes of special concern where sanitation systems are disrupted. The most vulnerable groups are children under five and the elderly. About 90 per cent of the deaths due to diarrhoea occur in children under five.

In some cases toxic chemicals may enter water supplies. Drinking water sources away from sources of chemical or microbial contamination therefore should be used. If this is not possible, alternative supplies of water may be required (e.g., bottled water or supplies through tanker trucks).

Safety of water

In an emergency it should be assumed that all water is at risk of contamination and this includes piped supplies. The water should ideally be treated.

The quality of urban drinking-water supplies is particularly at risk. Water treatment works may be damaged, causing untreated or partially treated water to be distributed, and sewers and water transmission pipes may be broken, causing contamination of drinking water in the distribution system.

Where there is evidence of faecal contamination of the drinking-water supply, it may be necessary either to modify the treatment of existing sources or to temporarily use alternative sources of drinking water.
It may be necessary to increase disinfection at source or to rechlorinate during distribution. In emergencies, such as during outbreaks of potential waterborne disease or when faecal contamination of a drinking-water supply is detected, the concentration of free chlorine should be increased to greater than 0.5 mg/litre throughout the system as a minimum immediate response.

Health risks related to stagnant water

Pools of standing or slow-flowing water provide a breeding ground for many insects, including mosquitoes that can transmit diseases. These mosquitoes are known as vectors. Different species of mosquitoes transmit different diseases, and they will also breed in different types of water collection vessels.

Treatment of water at household level and on a large scale

If safe water cannot be supplied, household water treatment is the effective, simple and inexpensive option. It is especially applicable to populations recovering from a disaster situation who often lack facilities and resources.

If chlorine or iodine tablets, or sachets of combined flocculant/disinfection powder have been distributed, water should be treated using the directions that come with the tablets. Water may also be disinfected with a diluted chlorine solution using household bleach or other chlorine sources.

Solar disinfection (SODIS) is an effective water treatment method that is applicable in emergencies, especially when no chemical disinfectants are available. Ultraviolet rays from the sun are used to inactivate pathogens present in water. This technique involves exposing water in clear plastic bottles to sunlight for a day, for example on the roof of a house. In emergencies, empty bottles can be used that are left over from an initial shipment of drinking water.

The use of simple ceramic pot filters is another option.
Options for getting safe water to people in affected areas

If water is deemed by local authorities to be unsafe, bottled water may need to be distributed or clean water transported by tanker truck to distribution points to meet immediate needs.

Another alternative would be to harvest rainwater and make it fit for consumption through simple treatment like SODIS, filtration or boiling.

Personal hygiene to be maintained in difficult circumstances

Despite water shortages and restricted sanitation facilities in emergency situations, it is critical to ensure that some of the available water supply is used for personal hygiene to minimize health risks. Messages about the importance of handwashing with soap at critical times—i.e. after defecation, after handling babies’ faeces, and before preparing food—are particularly important. As soap may be in short supply during emergencies, the use of ash, sand, or other culturally acceptable substitutes should be promoted.

Provision of sanitation facilities in affected areas

Emergency facilities are usually provisional and need to be progressively improved or replaced as the situation develops. Designated defecation fields or areas can be used where enough space is available. These work best in hot, dry climates and should be clearly marked, fenced (if possible) and protected against flooding. They should be located downwind and away from living areas, avoid watercourses, and be placed at a reasonable distance (minimum 50 metres) from water points. Shovels should be provided to families so that they can dig small holes to defecate into and cover their faeces with dirt. Collective trench latrines may also be an option. In longer-term situations or after the initial emergency period has subsided, it may be more practical to build simple pit latrines, VIP latrines, or pour flush latrines. In situations where the soil is rocky or the groundwater is very close to the surface, elevated platforms may be constructed.

As a general rule, individual family latrines are preferred, are more socially acceptable and can be maintained by the family. Latrines of all types need to be properly cleaned and maintained. Responsibilities for cleaning and maintaining latrines should be clearly spelled out. For collective latrines it may be necessary to hire someone to take care of them.

Water is essential for survival and is a priority in any emergency. To ensure clean water and a healthy population in camps, health professionals should be aware of and carefully follow the basic guidelines on water and sanitation.
Mental health in complex emergencies and conflicts: Promoting the well-being of the community

By Dr Vijay Chandra

Surrounded by the horrors of destruction, their every living moment filled with insecurity about their livelihoods and loved ones, with death often only a footstep away, people living in the midst of conflicts and complex emergencies are often in dire need of mental and psychosocial support. Unless these issues are fully addressed, there will be a huge gap in the health response to such an emergency.

Addressing mental and psychosocial issues does not, however, necessarily refer only to a medical need addressed by medical personnel. Indeed, the first response following any major emergency should be, and usually is, from the affected community. Rarely is external help available immediately after an emergency. The government usually mobilizes itself after several hours. So in these early hours the affected people have only each other to fall back on. The community has to mobilize its own resources...
until external help arrives. Therefore, the community needs to build its own resilience – a measure of a community’s preparedness for, and awareness of, the needs during an emergency.

This was clearly seen in the Bhuj earthquake of 2001 in Gujarat, India. People who had experienced earlier earthquakes knew exactly what to do. Led by the community leaders, each healthy person was given a role or task – healthy men took care of the injured and mobilized essential needs, while women and children were delegated to the community kitchen and to take care of the children, and elderly women sang bhajans (devotional songs). This provided a sense of purpose and unity to the people which helped them cope with the shock.

What one must not do in the early stage of the response to an emergency in terms of mental health is medicalize the problem. There is usually no immediate need for a psychiatrist to begin to prescribe medication. Their role at this time is to begin preparations, document the situation, train paramedical staff and community-based workers, and advise the government.

When the initial essential health, safety and security needs are taken care of, one needs to focus on the psychosocial needs of the community. This encompasses a wide range of social needs as well as psychological needs. For example, it might mean helping with obtaining identity cards, filling out forms, and other activities that are needed to get on with life. This is also when a strong shoulder is needed to lean on, and people should be allowed to grieve.

A trained local person is best suited to provide for these psychosocial needs. However, the suitable person needs to fulfill certain criteria – for example, they have to be able to identify with, and understand the nuances of, the local culture; they have to have an aptitude for listening and empathizing. Such local people then need to be given adequate and structured training in psychological first aid, usually well before an emergency occurs. This is where WHO plays a key role. The Organization has developed training material that can be used by other implementing agencies to conduct the training.

Ideally there should be one such trained worker for 20-50 families, depending on the intensity of the emergency. It is vital that this person visit the families they are responsible for every single day, in order to build a relationship and understand the needs of the families and reassure them of support. One key component of the local health worker’s role is to identify those who need to be referred to a psychiatrist, and distinguish these from others who will recover without medical intervention. To ensure that this is done correctly WHO has provided guidelines for “psychological first aid”.

In training community-level workers, they should be given some objective assessment tool to use as a guide to help them clearly categorize the people they are supporting into four groups:

- those who do not need any support;
- those who need a strong shoulder to cry on (i.e. psychological first aid);
- those who need counseling from a trained counselor;
- those who need medical help and should be referred to a psychiatrist.

It is at this stage, when those who cannot recover without medical help have been identified, that psychiatrists have a major role to play in the health response. But what are the criteria to determine who needs referral to psychiatrists? While implementing the assessment tool (described above) among a large population, patterns will soon emerge. This assessment tool will therefore be able to categorize the needs of the people in the local context. The outcome is likely to vary from place to place, as local experience and knowledge of the culture has to be taken into consideration in making this analysis.

More information on guidelines for mental health and psychosocial issues in emergencies is available at www.searo.who.int/eha.
After two decades of conflict, Asia’s longest running civil war came to an end in May 2009 when the Sri Lankan army defeated the separatist Liberation Tigers of Tamil Eelam (LTTE). However, from the health perspective, the challenges are only beginning, as the most recent conflagration has displaced more than 280,000 people – the size of an entire city. They are now accommodated in Vavuniya, Jaffna, Mannar and Trincomalee. These internally displaced persons (IDPs) have to be provided with basic services — food, shelter, safe water, and access to adequate health care. These are people who have suffered from years of conflict.

At the same time, the needs of the host population of these areas must not be neglected either.

Initially, as displaced people poured in from the No-Fire Zone (NFZ), the IDP camps were created in an emergency...
manner to accommodate them, and planning for the basic services have not always been good. Currently, some IDP camps are overcrowded, while others have half the number. The Government of Sri Lanka is creating new IDP camps in Cheddikulam to relieve congestion in existing camps and to accommodate IDPs who have been staying in schools and other public places since the most recent hostilities began.

The current situation

Ensuring adequate health services for a quarter of a million people living in such close quarters is challenging. However, coordinated by the Sri Lankan Ministry of Health (MoH) and WHO, more than 17 partners are providing a range of services, including the governments of India, Italy and France. Fourteen primary health-care centres have been set up inside the camps, and four referral hospitals, in Vavuniya, Mannar, Cheddikulam and Poovarasankulam, have been equipped to treat more serious cases. Mobile health teams from the MoH and health partners provide curative and preventive health services in the temporary sites. In addition, as some of the health staff are themselves IDPs, home-based activities such as antenatal care (ANC), child welfare, family planning, nutrition, hygiene promotion and disease surveillance are also being carried out. Doctors and nurses are working in referral hospitals throughout the night on a rotational basis.
Many of the IDPs are in need of mental health and psychosocial support, and this is being provided by the Ministry of Health through psychiatrists and community support officers. Those needing further treatment and interventions are being referred.

A Communicable Diseases Surveillance System is in place and is being implemented by the MoH and health partners. A “Communicable Disease Weekly Update” has been produced by WHO and the MoH, which provides weekly information on communicable diseases in the IDP camps. This update is being shared with all stakeholders.

**Challenges**

The challenges are enormous, largely because of the sheer scale of operations needed. The most urgent issue is the availability of clean water and adequate sanitation facilities. Irregular garbage collection compounds the problem of sanitation further.

There is a constant turnover of medical staff to meet all the health needs of this large, displaced population. As doctors and nurses are being mobilized from other parts of the country to fill this need, logistical issues arise, such as providing them with accommodation and supporting facilities.

Communicable disease surveillance needs to be further strengthened. In a recent rapid assessment conducted by the MoH, elderly people in the camps showed poor nutrition and this would need to be addressed as well. Rehabilitation services need to be extended to people with disabilities; to better identify their needs, a detailed disability survey and needs assessment has been conducted by the Ministry of Social Services and Social Welfare in the six IDP camps.

**WHO’s interventions**

WHO has attempted to address many of the challenges. WHO continue to advocate and actively engage with the MoH and leads coordination with health partners in providing services as needed.

WHO has also supported the Ministry of Health by providing salaries, accommodation for health staff, and vehicles to transport them from Vavuniya town to the camps. Temporary housing for doctors and nurses has also been built.

To meet the increased demand, hospitals have been upgraded with WHO support—from purchase of hospital beds and equipment to the construction of temporary wards in district hospitals.
WHO supported the capacity building of MoH staff on disease surveillance, and is engaging health partners in collecting information through the weekly health cluster meetings at Vavuniya and fortnightly meetings at Colombo.

With WHO support for the Mental Health Unit of the MoH, all the IDP camps in Cheddikulam have psychiatrists who go on house-to-house visits to provide patients with mental health and psychosocial support services. WHO will also continue to support the training of additional Community Support Officers (CSOs) and medical doctors on mental health issues.

A quick assessment supported by WHO and conducted by the nutritional unit of the MoH has revealed that a high percentage of the elderly population is malnourished and anemic. With available funding, the Organization will support the MoH to conduct a random sample survey in Cheddikulam to assist in the formulation of strategies to address malnutrition amongst the elderly. This survey would also assist the MoH and WHO to come up with local reference numbers based on international standards.

Another effort is to streamline maternal and child health (MCH) services in the IDP camps with special attention to services for antenatal, intranatal and postnatal care for pregnant mothers.

Through active coordination, the health partners have been able to provide equipment, medicines and supplies to the MoH, and avoid overlap. WHO has provided emergency health kits to the MoH, while other partners donated equipment such as blood analysers and essential medical supplies.

**The way forward**

WHO will continue to work with the MoH to identify and address the needs and gaps in the IDP camps. In addition, through its role as the Health Cluster Lead, WHO will also actively engage health partners to address gaps and needs that have been identified in the provision of health-care services.

Strengthening the disease surveillance programme in the IDP camps is a priority, and WHO will work towards this through capacity building of health staff from the MoH and international and national NGOs. Surveillance tools and facilities will also be provided to improve on reporting and the transmission of reports, and share case definition and treatment guidelines with all stakeholders.

The Government of Sri Lanka has prepared a 180-day plan for early resettlement of IDPs under a Presidential Task Force. Relevant ministries including the Ministry of Health have developed their respective plans, and have conducted assessments in conflict-affected areas.
Nepal’s history qualifies it to be classified as a country that has experienced a “complex emergency”, and which still experiences different aspects of it to some degree.

Nepal is a landlocked country between China and India. Its landscape can be divided into three areas; the terai, which is the flatland, the hill area, and the mountain area of the Himalayan mountain range. The history and culture of Nepal have also developed along these divides. It has a population of around 27 million (projected figure based on the 2001 census), of which 48% live in the terai area and only 7% reside in the mountain area.

As a result of the diversity in landscape and the combination of multiple ethnic groups and cultures, Nepal has experienced a high number of natural and man-made disasters. It is prone to annual flooding in the terai area; landslides and fires plague the hill areas; and the shifting of the glacial lakes adds to the dangers in the mountain areas. Nepal also experienced internal conflicts up to 1990, when a multi-party democracy was established. The short-lived peace was, however, broken in 1995 when dissatisfied factions took up arms, which led to a ten-year conflict and the loss of more than 13 000 lives. In 2006, the king of Nepal ended monarchial rule, leading to the restoration of the parliament. Afterward, peace prevailed to some extent, but there continues to be conflict between the various ethnic and political groups, especially in places of poverty and lower levels of economic development.

During the period of unrest, much of the health system in Nepal was affected. Health facilities were attacked and many were damaged. Looting of drugs in remote areas was rampant. The lack of health workers due to injuries, death or displacement and the increase in the number of injured led to serious shortfalls in the health sector. Outreach services, which are the main means of health-care provision, especially in remote locations, were hampered by the ongoing
The term “complex emergency” is officially defined as “a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single agency and/or the ongoing United Nations country program.”

– Inter-agency Standing Committee (IASC), December 1994.

By Ms Hyo-Jeong Kim
conflict. Transport of essential supplies and commodities was impeded due to bandhs, roadblocks, checkpoints, and destruction of bridges and roads.

Despite such shortcomings, there were also some positive outcomes that showed the resilience of the health system of Nepal. The grassroots character of the health facilities helped the sector to function even during the conflict. The health workers voluntarily set up clinics to treat all those that they could reach. Health personnel, together with the community and relevant partners, provided support with no regard to the political affiliation of the patients to make a “bridge for peace” at all levels. The health workers delivered essential health-care services, including support for vaccination campaigns, and provided reproductive health care.

WHO worked closely with the Government of Nepal, UN agencies and other partners on the ground to provide essential health-care services to those in need. The focus was on developing the capacity of the existing health sector to continue providing health-care services. WHO provided training of health-care workers on rapid response, hospital preparedness for emergencies, and mass casualty management. The trainings were supplemented with "minimum kits", which included items that would allow those trained to implement what they had learned. The kits included stretcher, rigid spinal board, neck collar, splints, tent, kerosene lamp etc, as well as first aid kits.

Coordination activities were also supported through the strengthening of the Emergency Health and Nutrition Working Group, which comprises UN agencies and NGOs working in the field of health and nutrition, as well as the government. The governmental coordination mechanism was also strengthened through the revitalization of the Disaster Health Working Group, which brings together all the divisions under the
Department of Health Services. This allowed for a more extensive involvement of relevant technical divisions in emergency work.

The Immunization Preventable Diseases (IPD) programme demonstrated that it is possible to implement country-wide public health campaigns (e.g. measles vaccination) in areas with blurred lines of authority. The field staff were able to continue implementing routine vaccination to children even in the affected areas. In fact, the health workers were sometimes the only non-conflict-affiliated persons allowed to enter certain areas.

The continuation of the programmes despite the political and natural threats allowed the people of Nepal to enjoy a certain level of good health during this period. The fact that there were no major outbreaks even among the displaced population, and the high rate of immunization shown in the recent assessments, attest to this. Even in the cantonments that were set up to house the “rebel” groups during and after the conflict, health care continues to be delivered under the careful monitoring of the Ministry of Health and Population (MoHP).

However, the situation in Nepal continues to be volatile, especially due to recent political developments, coupled with the continuous threat of natural disasters such as floods and landslides. WHO is supporting the MoHP in monitoring the health situation in Nepal, in case further action is needed. Activities to support the peace process also continue. WHO’s Nepal country office recently hosted the multicountry workshop on “Health as a Bridge for Peace”, where the possible role of health workers in the promotion of peace was discussed at length. Participants came from the MoHP, and some concrete ideas were taken back to the ministry for further implementation in the future. In addition, efforts continue for preparing the country for any natural or man-made disaster through the training of health workers on emergency preparedness and response, stockpiling of essential drugs and supplies, and institutionalizing the disaster response by operationalizing the emergency preparedness plan of the MoHP.

Such efforts will need to continue in the future to ensure that health-care services are not disrupted by the political weather in Nepal. In order for this to happen, health and humanitarian actors need to advocate for commitment from stakeholders to ensure the security of health workers, which requires appropriate coordination among sectoral ministries, partners and the community. There needs to be skills improvement in health and human resources at all levels of the country, down to the health sub-post. Also, active participation of the community should be encouraged through advocacy and awareness-raising. In addition, constant supervision, monitoring and evaluation will be needed to ensure that all objectives are properly met.

In order for Nepal to fully achieve development, constant attention must be given to ensure the peace process takes root in the country. The health sector has proven in the past that it can act as one of the conduits for change. One of the key roles of WHO in the future will be to ensure that this role is kept up, and that the health sector becomes stronger so as to be able to fully prepare for and respond effectively to any disasters that may afflict the country.
Life on the Ground in Vavuniya

By Dr N P Sumanaweera, Head, WHO Field Office in Vavuniya, Sri Lanka

I first went to Vavuniya in northern Sri Lanka to set up the WHO field office in September 2008. The current conflict was then intensifying. More and more people were pouring into Vavuniya. I was initially alone there with my driver, staying in hotels for many months. My job was to assist the health authorities in the Province, District and the Ministry of Healthcare and Nutrition to provide services to the internally displaced persons (IDPs). Because of the conflict, it was then dangerous to travel around, and there were also many restrictions from the authorities. With the number of displaced people in the area increasing, my work load also increased tremendously, and I was glad to welcome a logisitician, an epidemiologist and a secretarial assistant to the team a few months later.

As one can imagine, ensuring the health needs of approximately 290 000 displaced people is quite a challenge. My day begins at 5 a.m. I get to work by 8.00 a.m., and am in the office till 7.30 p.m., frequently longer. WHO has been providing support in different ways – leading the coordination of agencies working on health along with the Ministry of Healthcare and Nutrition; providing logistical support and guidelines; and assisting in the upgrading of hospitals to be able to cope with the sudden spurt in demand, to give just a few examples. To ensure that everything goes smoothly,
our team has to visit the five big camps (called five zones) many times a week, then visit the primary health care centres, the referral hospitals in the camp, as well as the Vavuniya General Hospital and the Cheddikulum Base Hospital. Because of an outbreak of chickenpox in January and infective hepatitis in May one small hospital was converted to an isolation centre. Our team had to conduct disease surveillance activities on a daily basis.

In addition to the Ministry of Healthcare and Nutrition and WHO, there are many international agencies and international and national NGOs working in various aspects of health in this emergency. In order to ensure that there is no overlap and the priority needs are addressed in the most efficient manner, all of us meet regularly at the coordination office in Cheddikulum and in the weekly Health Coordination meeting under the chairmanship of the Regional Director of Health Services. We also meet representatives of the other sector leads of the government at least once a week.

Initially, because of the conflict, there were restrictions in our work. Supplies would sometimes get held up and arrive late. For example, we were providing supplies for expansion of the hospitals and Primary Health Care Centres in the IDP sites.

I have been working in conflict-affected areas in various locations since 1990. The biggest challenge this time is the sheer number of displaced people. Because of the sensitivity of the situation, one has to negotiate and convince the authorities of what we need to do and get the necessary access to do so.

It has to be mentioned that the colleagues in the Country Office and the others encouraged us by visiting the area many a time. The support of the other agencies we received was enormous.

WHO’s mandate in such a situation is quite clearly defined. But authorities often ask for things outside our mandate. So we have to convince them of what we can and cannot do to help. It does require diplomatic skills! We do understand their needs, and do our best to oblige within our scope.

At the end of the day, we can feel satisfied if we feel we have done a little bit to help improve the lives those young children, those families in the camps who have been through so much and lost so much.
In May 2009, an outbreak of diarrhoea started in a very remote location of Nepal. Nepal is a country composed of three distinct geographical features, commonly termed the terai (flat land in the south), hill (mountain area less than 5000 metres above sea level) and the Himal area (mountain area higher than 5000 metres above sea level). Contrary to common perceptions, the most remote districts are located in the hill area where access is hampered through lack of roads and airstrips. Jajarkot district, where the outbreak was first reported, is considered the third most-remote district in Nepal.

As a means to respond to the outbreak, WHO mobilized a team consisting of an epidemiologist and an emergency health officer (myself). The mission’s objective was to establish a surveillance system and to strengthen coordination of the response activities.

The way to Jajarkot started with a bumpy ride to Nepalganj, from which we took a helicopter to the hilly district. There are no roads linking Jajarkot district to the rest of the country; the only way to access the district is on foot, if you do not a helicopter. This resulted in drugs and supplies being stranded on airstrips that are at least three to four hours on foot away from the district.

Jajarkot is one of the districts in the west of Nepal that experienced severe food shortages following many months of drought. By the time we reached there, the rains had started, leading to diarrhoea outbreaks. However, water was not plentiful and food was scarce. We were lucky in that we had managed to bring our own water purification tablets with us. The local people were drinking water straight from the source with no purification measures taken. In terms of food, we were also treated very well, being offered fresh chicken. However, it was obvious that this was a temporary measure of hospitality offered to foreign visitors. The locals ate the standard dal bat (rice and lentils) all the days that we were there.

Because of its remoteness, Jajarkot does not have many visitors. As a result, we had the unique experience of living in much the same way as the locals. The hotel that we stayed at had
mud floors and tin walls. There was no washing facility, and the toilet was down a steep slope. The hotel owner was in the process of building an outhouse and a shack for taking showers behind his water tanks, which were located right next to the eating area. He promised to have better facilities in a month’s time, by the time we visit next, hopefully.

As many of the diarrhoea cases were being reported from villages in even more remote locations, on the last day of our visit we took a helicopter and visited three villages in sequence. All three villages did not have proper helipads; it was lucky we had very experienced pilots (the pilots normally operated in the Himalayas on rescue missions) who were able to land us on the smallest strips of land. At one point, we did nearly land in a rice paddy, but were saved from having to wade through the shallow waters due to the land being slanted.

The conditions in the health facilities at the village level attested to the remoteness. None of the health facilities that we visited had proper beds. The patients were laid out on the floor with only a blanket between them and the mud floor. There were no toilets and no hand-washing facilities. In fact, soap was obviously missing.

The helicopter drew a large crowd in each village; we took advantage of this and gave quick lessons on the use of oral rehydration salts (ORS) for diarrhoea and hand-washing. However, there is still much to be done to improve the hygiene and sanitation of the people, which is the only sure way to control outbreaks of diarrhoea.

Despite all the hardships being experienced by the villagers, at each location we were greeted with warmth and hospitality, and presented with traditional garlands made of flowers and grass. We were blessed and accepted into the community, even for the short period of time we spent in each Village Development Committee (VDC).

The trip allowed us to see the resilience of human nature and how people managed to survive in even the most difficult conditions. It pained me to leave the people there without being able to do more for them. But it was good to know that these people had the ability to survive, and would be able to benefit all the more from our actions.
The Republic of Indonesia is a large and complex country. It consists of 17,000 islands with more than 500 languages and dialects. Complexity in culture, tradition, religion, language, ethnicity, and politics has often triggered violence, conflicts and crises.

Indonesia has also experienced a number of devastating disasters. In 2004–2008, there were 771 emergency and disaster incidents affecting 124 provinces and 540 districts, leaving approximately 100,000 dead, 740,000 injured and 3.7 million displaced. All emergencies and disasters had an effect on the health sector not only in terms of high demand for services but also because health staff became victims and many health facilities were damaged.

The concept of health as a bridge for peace was introduced to Indonesia in 2000, through a national workshop held in Yogyakarta targeting a group of health professionals working in the conflict-prone areas of the country. In 2002, the Ministry of Health, WHO and Center for Security and Peace Studies, Gadjah Mada University, initiated a “Health as A Bridge for Peace” (HBP) Project with funding support from Norway. The project ended in 2004 and is now streamlined back into the capacity building activities of the Disaster Risk Reduction Programme for the health sector in Indonesia. This article highlights two different perspectives on the conflicts that happened in Maluku and Aceh Province.

The Maluku Conflict

In 2002, there was a major conflict between Muslim and Christian religious groups in Maluku and North Maluku provinces in eastern Indonesia. Families, friends, communities, private and
public workers, and those who lived and worked together on a daily basis were divided by their religious beliefs. Many people died in the conflict while others were injured, traumatized or displaced, and buildings and homes were damaged. Health staff, their families and facilities were also targets. The routine health system collapsed as health staff were separated according to their religion and communities and people became suspicious of health services provided by doctors and nurses of the other religion. Roads were blocked, and community security forces became powerful. As the magnitude of the conflicts grew, the Indonesian Government sent military Special Forces to secure the region.

The health sector faced serious challenges. Health staff could not attend health facilities located where opposing religious communities lived. Health facilities and offices were split and run by staff from one religious group only. Consequently, patients could not be transferred to appropriate health facilities due to differences in religion. Many health staff were attacked, died or were injured and many left the region to escape the conflict. This lack of health services then triggered disease outbreaks.

The Ministry of Health, WHO and health partners played an important role in Maluku’s conflict resolution by introducing the concept of “Health as a Bridge for Peace” to the Ministry of Health at central level, as well as advocating it with training materials, a module, and a strategic plan to the local authorities, community leaders and health staff from both sides. At that time, WHO opened field offices in Maluku and North Maluku provinces in collaboration with other UN agencies guided by the UN Office of the Coordinator for Humanitarian Affairs (UNOCHA). In collaboration with UNOCHA, a series of workshops were conducted on health professional ethics, human rights, negotiation skills and essential health topics to build back the trust among health staff first.

Hindu and Buddhist health staff, as well as those from other provinces, were mobilized as neutral parties to fill the gap in many health facilities. By using one entry point relating to a major health issue that affects vulnerable groups of both sides (in the case of Maluku it was measles outbreaks) health staff and communities were brought together to control it. As neutral organizations, both the United Nations and INGOs formed teams with local health staff, organized field travels to reach communities separated by conflict and provided health services. Trauma centres were established in strategic locations and provided health services and counseling to the communities. Health therefore played a major role as a bridge in solving a conflict that originated outside the health sector.
The Aceh Conflict

The separatist movement in Aceh, demanding the secession of the province since 1976, created a regional humanitarian crisis leading to war between central government armed forces and separatist militants. Based on the experience learnt during the Maluku conflicts, the “Health as a Bridge for Peace” project was further adapted to address the Aceh conflict which was based on disparity of the sharing of resources between the central and regional governments. In addition to the chronic conflict, the province suffered from a major disaster (the earthquake and tsunami of 2004) which changed the overall situation. All parties, government and separatist groups, accepted that the natural disaster had overshadowed the man-made disaster and major humanitarian support was needed to heal the affected communities.

The challenges faced by the health sector during the conflict in Aceh are different from Maluku’s situation. In Aceh, health staff were sandwiched between central government troops and separatist groups. The security of health staff was not ensured and many became victims of the conflict. Large-scale emigration of health workers left human resources at only 30% of what was needed to provide health services. The province was divided into two areas: “gray” where health staff could still operate, and “black” areas where staff could not enter due to armed conflict. Referral of patients as well as treating patients from different sides of the conflict made it difficult to manage cases in health facilities. Many rural health facilities were closed and home-based clinics were substituted.

Due to escalation of armed conflict in 2003, all INGOs and international staff from UN agencies were no longer allowed to work in the province except EHA WHO. This reduced the capacity to fill essential humanitarian needs. A special permit is needed to travel to the province, as well as permission from the military command post in the province. The chronic conflict left the province traumatized, both physically and mentally, including the health sector. Shortages of health supplies and difficulty in communication and transportation worsened the health situation, and the province came lowest in all health indicators compared to other 33 provinces.

The Ministry of Health, WHO and partners in conflict resolution modified the “Health as a Bridge for Peace” project to address the needs of Aceh, and a strategic plan of action was developed. WHO opened field offices in Banda Aceh, capital of the province, in collaboration with UNICEF, WFP and guided by UNOCHA to advocate the concept and strategic plan to the local authorities, military personnel, community leaders and health staff in gray areas, as well as to identify mediators to pass on the concept and provide health services to the separatist groups in the black areas. A special incentive system at MoH central level was established to mobilize...
health staff on a rotational basis of six months to work in Aceh province. Training materials were modified and trainings conducted on “Health as a Bridge for Peace”, health professional ethics, human rights and negotiation skills and essential health-related topics and subjects to build up the capacity as well as confidence among health staff first, and then with the communities.

Psychosocial and mental health subjects were integrated into the training materials, using the main health-related issues as entry points because they affected both sides during the conflict. In Aceh province, a scabies outbreak, malnutrition and measles outbreaks were used to motivate, mobilize and support staff to revitalize the health services in many gray areas. As the provincial referral mental hospitals could no longer cope with the traumatized patients, trauma care centres were opened in all district hospitals to provide health and counseling services. Incentives were given to health staff working in Aceh for promotion and special allowances and health supplies were provided.

In both the Maluku and Aceh conflicts, health workers played a major role and the focus was on increasing their trust and confidence to perform health services. Consequently the affected communities once again received essential health services and found neutral ground in health upon which to start negotiation and reconciliation for overall conflict resolution. At present, Maluku is enjoying peace and stability and Aceh province is in the development phase due to humanitarian support and special autonomy as a result of a peace agreement between the central government and separatist groups.

What we have learnt

Each conflict is unique, and all humanitarian projects and programmes need to be tailored to the situation. The focus should be to strengthen health staff capacity first, and through them to reach the communities. Training alone cannot change the trust and confidence of the health staff and communities. A supporting incentive system, mobilizing resources, providing supplies and meeting essential needs are the keys to success.

Based on the experiences and lessons learnt from many different emergencies, disasters, conflicts, and crises in the country, the Indonesian Ministry of Health has developed and is implementing a Disaster Risk Reduction Programme for the Health Sector (DRR-PHS). The programme has established nine Regional Crisis Centers and International Training Consortium on DRR, produced standard operating procedures (SOPs), training materials, and guidelines to further strengthen the capacity of the health staff and partners. "Health as a Bridge for Peace" learning materials have now been integrated into the existing psychosocial and mental health training modules to ensure long-term sustainability. In addition, the new training methodologies used in ITC-DRR ensure participants understand, practice, change and improve positive attitudes by sharing knowledge and skills in the area of human rights, ethical issues, different norms, team building, communication and negotiation, and conflict management and resolution.
As a consequence of the conflict of 1999 in Timor-Leste, the situation was a combination of a health system that needed rebuilding and a health profile characterized by a high prevalence of basic health problems:

- High infant mortality rates (estimated then at 125 per 1000 live births) and high maternal mortality rates (estimated at 550–900 deaths per 100000).
- High morbidity and mortality in children due to pneumonia and diarrhoea.
- High prevalence of communicable diseases, including malaria and tuberculosis.
- Approximately 75% of health facilities were damaged; a third of these health facilities (35%) were totally destroyed. Most equipment was damaged beyond use and supplies had been looted.
- More than 80% of medically qualified staff had returned to Indonesia and only 25 East Timorese doctors and one specialist remained.
- The central health administration was defunct.

In this situation, the local health staff did their best to reorganize and provide services, and the international community responded quickly to the need. In particular, international emergency relief nongovernmental organizations (NGOs) moved in to provide health services at many points across the country. These NGOs were assigned to districts and health facilities and managed them till December

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1 Timor-Leste was a province of Indonesia till the referendum of 1999 which resulted in a violent conflict and after which the country was proclaimed as the newest in the international community in 2002.
2001. Facilitated by the existence of an East Timorese Health Professionals Working Group, the UN Transition Administration in East Timor (UNTAET) established the Interim Health Authority (IHA) in February 2000. This body brought together remaining senior East Timorese health staff with the UNTAET health staff to restore health services to the people as rapidly as possible and develop a sustainable health system for the future.

Several significant steps were taken to rebuild systems and address needs at the same time, and some of these were:

- establishment of government/interim authority coordination
  - The Interim Health Authority, which later evolved into the Division of Health Services of the East Timor Transitional Authority (ETTA) Department of Social Affairs, and was eventually to become the Ministry of Health (September 2001) was the main coordinating body with the UNTAET, the World Bank and the UN agencies and NGOs.
- availability of funds
  - Through donations from the international community, the Trust Fund for East Timor (TFET) and the Consolidated Fund for East Timor (CFET)\(^2\) were managed by the World Bank and the ETTA, respectively. Other resources for essential elements of the health system were also provide by UN agencies and NGOs.

\(^2\)TFET was for infrastructure and development projects and CFET was for recurrent budget of the East Timor interim authorities.
a focus on policy development to shape and run the health system
- the health authorities, as they evolved, focused on developing policies for priority health issues and programming in order to operationalize a health system that is responsive to the people’s needs.

a decentralized system was the focus of the rehabilitation plan
- a comprehensive plan and programme was prepared for rehabilitating and developing the health systems, a key part of which was a strong decentralized district health system; considering the geographic characteristics of the country, this was most appropriate.

transfer of responsibility to nationals
- Once the decision to withdraw the international NGOs was made in September 2000, the recruitment of nationals to run and manage the health facilities and district health units began. Certainly this is the most important achievement of the transition and rebuilding of the health system. By late 2001—in a little more than 18 months—a complete East Timorese Ministry of Health had been put in place and over 800 health staff had been recruited and were working across the country. All community health centres were staffed and functioning, as were most of the health posts and mobile clinics.

establish a drug supply and distribution system
- this was one of the important projects as part of the health system rehabilitation and development plans that was developed from policies to procedures—procurement, inventory and distribution

international support only in areas that were deemed necessary
- although there were existing gaps in capacities in various parts of the

Highlights of WHO’s work in Timor-Leste in the early post-conflict period
- Support to policy and programme development for the health system.
- Support to the reorganization and management of human resources for health, developing post descriptions in line with the district health system focus for rehabilitation.
- Introduction and establishment of the Integrated Management of Childhood Illness (IMCI) through the adaptation of a Bahasa Indonesian version of the IMCI materials and the training of trainers.
- Support to improving reproductive health services, with a focus on introducing and monitoring midwifery standards and identifying and addressing deficiencies.
- Support to the tuberculosis (TB) programme together with Caritas
  - Over 6000 cases of tuberculosis were detected and placed on treatment according to the directly observed treatment strategy. By the end of 2001, the programme covered all districts and many sub-districts.
- Support to areas of health promotion, disaster preparedness and response disease surveillance, improvement of clinical skills of nurses.
health sector, the MoH was selective about which areas to ask for technical assistance in, focusing on priority needs.

Although these were successes, there were other constraints as well, such as availability of expertise; the competing priorities and needs vis a vis the medium- and long-term goals that had to be addressed in the present; and enforcement of standards, all of which created limitations in the progress of policy development and project implementation.

Looking back at the health situation then and the health system post-conflict, it is clear there has been much improvement. Health priorities are addressed systematically and the district health system continues to provide preventative and curative services. Although new challenges emerge, whether political or health-related, the MoH has proven time and again that its policies and systems can handle such situations.

All in all, this is a process that continues to evolve. As with any health system, Timor-Leste’s continues to hold to one of the most important principles: that it is a national health system, which is determined by the people of Timor-Leste. To paraphrase the MoH slogan post–independence, Ita nian saude, iha ita nia liman rasik ("Our health is in our own hands "). And this is how every health system should be approached, that needs to be rehabilitated in the wake of a conflict.

References


Using Health as a Bridge for Peace In the South-East Asia Region

By Dr Supriya Bezbaruah
“The role of physicians and other health workers in the preservation and promotion of peace is the most significant factor for the attainment of health for all” (World Health Assembly, Resolution 34.38, 1981)

In 1984, as guerillas and government forces were engaged in fierce conflicts in Central America, the Pan American Health Organization (PAHO) launched a unique health intervention – immunization campaigns that promoted collaboration between the warring factions. The success of this campaign showed the world that health can serve as a bridge to promote understanding among people divided by war, and the phrase “health as a bridge for peace (HBP)” was first coined. This concept was formally accepted by WHO in the Fifty-first World Health Assembly in 1998, and is now being followed by the Organization wherever there are conflicts. The concept has evolved over time and been adapted to specific situations.

Officially, WHO defines this concept in the following terms:

"Health as a Bridge for Peace (HBP) is a multidimensional policy and planning framework which supports health workers in delivering health programmes in conflict and post-conflict situations and at the same time contributes to peace-building. It is defined as the integration of peace-building concerns, concepts, principles, strategies and practices into health relief and health sector development."

In areas of conflict, the health of the entire population is affected, increasing disease and disability. Continuous strife leads to lack of resources for health care, poor governance, and poverty. Indeed, more women and children die from preventable diseases, malnutrition and childbirth complications in conflict zones than from actual violence or brutality. Seven of the ten countries worldwide with the highest child mortality rates have experienced recent civil conflicts. The main causes of death of children under five years in these countries are not injuries as might be expected, but acute respiratory infection (ARI), malaria, diarrhoea and neonatal disorders. Addressing the health needs of populations is therefore an important first step to minimizing the effects of violence and promoting peace. But the wider peace benefits of health initiatives must eventually be linked to broader questions of justice.

HBP is of particular significance in the WHO South-East Asia Region, where four countries are in either immediate post-conflict transition (Indonesia, Nepal, Sri Lanka and Timor-Leste) or manifest localized violent conflict within border communities (Thailand).

Given the number of countries affected, health practitioners and planners in this Region may need to increase their conflict sensitivity in delivering health programmes to affected communities. Integrating peace-building concerns, HBP concepts, principles, strategies and practices into health relief and health sector development plans in conflict and post-conflict situations seems a vital part of community recovery. The sensitization and training in the utilization of concrete HBP tools to increase conflict sensitivity in the day-to-day work of the ministries of health (and others involved in health) becomes important within these country contexts.

An Inter-Country Workshop on “Health as a Bridge for Peace” in the WHO South-East Asia Region was organized in Kathmandu, Nepal on 21-24 April 2009. It had three major aims:

- To harness the collective experience of the respective country offices to build a common understanding on both the conceptual and programmatic aspects of “Health as a Bridge for Peace”.
- To provide an overview of the range of evidence-informed and field-validated methodologies and technical tools available.
- To identify key skills and competencies necessary for health professionals to contribute to peace building.
The workshop was attended by representatives of the Ministry of Health, a national level nongovernmental organization with a history of working on peace and reconciliation in conflict-affected communities, and WHO regional and country office representatives.

The participants discussed various aspects of using health as a bridge for peace in the context of this Region. One important issue was to have a rights-based approach to programmes, encompassing human rights law, international humanitarian law and refugee law. It is important for health workers to know these laws and integrate them into their work, especially when they are dealing with internally displaced people. Health workers are expected to remain neutral in conflict and post-conflict settings. But no intervention, however well-intentioned, can occur in a complete vacuum, and there is likely to be some form of bias, real or perceived.

Peace-building is complex, even in a generally beneficial field such as health. As in medicine, one fundamental rule for HBP to be effective is “first do no harm”. This may seem simple, but in reality means that every intervention needs to be well-thought out. For instance, a childhood immunization programme that aimed at “building bridges for peace” at Croatian and Serban border communities took a disastrous turn when Serbian children were given a vaccine with a Croatian label. The Serbian parents questioned the efficacy and reliability of the vaccine. This showed how poorly planned interventions can contribute to exacerbating tensions in conflict-ridden situations.

To help develop programmes that will be effective as HBP, a Health and Peace-building Filter tool has been devised by the University of New South Wales (UNSW), Australia. It is based on five core principles:

- Cultural sensitivity: recognizes, respects and appreciates cultural differences, such as religions, language groups, and belief systems about health and well-being.
- Conflict sensitivity: understanding different reasons for tensions; thinking how health care could be responsive; building trust with the community.
- Social justice: inequities in health-care access, delivery etc.; discrimination based on gender, race, political affiliation.
- Social cohesion: understanding changing social conditions; bringing groups together through joint health action.
- Good governance: good coordination; effective mechanisms for action; enhancing communities capability; transparency.

Each of the countries in a conflict or post-conflict situation applied their interventions through the HBP filter to work out an effective action plan.

Thinking through an intervention in conflict areas also involves a thorough analysis of the health system. Health systems can change during a crisis. This can have long-term effects – when “action is always ahead of understanding”, major mistakes are made and valuable opportunities missed. Often, post-crisis, donor money exists to rebuild the system. Unless the system’s weaknesses and faults are thoroughly and realistically analysed, the risk of wrong, evidence-poor decisions is high – and these decisions may remain in place for decades, hampering rather than helping the communities.

In summary, health as a bridge for peace can make a huge difference to communities and countries suffering from conflict. But it is complex, and needs to be carefully implemented, taking into account the local scenario.
Cyclones, tsunamis, floods, earthquakes – the South-East Asia Region regularly faces some of the world’s worst natural disasters, which often leave hundreds of thousands of people devastated. Speedy assistance can make all the difference to their survival, yet most emergency funding arrives a few days or even weeks after the disaster.

The South-East Asia Regional Health Emergency Fund (SEARHEF), established in 2007, is intended to bridge this gap.

Several features make this fund unique. The first is the simplicity of application – a request in writing, even through email, from the government or from the WHO representative of the disaster-affected country. The second feature is the speed of disbursement – although the sums are modest compared to other funds, with a maximum allotment of US$ 350 000, the first tranche is usually released within 24 hours of receiving the request.

SEARHEF was first used to provide vital life-saving medicines and supplies following Cyclone Nargis in May 2008. It has subsequently been used in a number of emergencies, large and small, making a difference to hundreds of thousands of the most vulnerable disaster-affected people in the Region.

Cyclone Nargis, Myanmar, May 2008

On 2-3 May 2008, Cyclone Nargis rampaged through 47 townships of the Ayeyarwady and Yangon districts of Myanmar, with winds up to 160 kilometres per hour and 15 hours of continuous lashing rain. The cyclone blew away houses and ripped off roofs – including those of some health centres, rendering many nonfunctional just when their services were most needed. The main sources of fresh water were contaminated by sea water that surged inland. Stagnant pools of water, ideal for breeding mosquitoes, added to the risk of malaria and dengue. The storm left more than 130 000 dead
or missing and 19 350 injured according to official figures, making it one of the worst natural disasters in the Region.

At the request of the WHO representative to Myanmar, US$ 350 000 was disbursed for this emergency, the first US$ 175 000 being sent within 24 hours. This enabled WHO and the Myanmar Ministry of Health to acquire essential medicines and equipment to treat the sick and injured. Chlorine tablets and bleach were bought to purify water. Fogging machines and insecticide-treated bednets helped in protecting the affected people from vector-borne diseases like malaria and dengue. SEARHEF thus covered the Myanmar Ministry of Health’s needs for the affected population weeks ahead of the bulk funding mechanisms of the United Nations, such as the Flash Appeal and Central Emergency Relief Fund (CERF).

Flash floods, Sri Lanka, June 2008

On 2 June 2008, heavy monsoon rains triggered flash floods in southwest Sri Lanka. The water swept over five districts (Kalutara, Ratnapura, Colombo, Galle and Gampaha), killing 16 and affecting 173 778, according to official estimates. Landslides further added to the emergency. Immediately after the disaster, the Sri Lankan Ministry of Health and Nutrition requested 2 500 000 LKR (around US$ 23 500) from WHO.

The challenge in this emergency was to prevent these health issues — the risk of water-borne diseases, dengue and malaria, for example — from spiraling out of control. That is where SEARHEF funds made a difference.

Funds were used to purchase basic drugs and chemicals to treat the wounded and sick, and to procure food for volunteers and the displaced alike. Disinfectants were bought and wells were cleaned. Disease surveillance systems were set up quickly to prevent any outbreaks. SEARHEF played a vital role in funding health education activities to make the public aware of the potential dangers and how they can be prevented. Leaflets, posters and banners were used to communicate these messages. As a result, no disease outbreaks were reported.

Conflict in northern Sri Lanka, September 2008/February 2009

More than two decades of conflict between the Government of Sri Lanka and the Liberation Tigers of Tamil Eelam (LTTE) separatist group resulted in more than 65 000 deaths, according to humanitarian agencies. As the conflict escalated in September 2009, thousands more were displaced. By February 2009, as the Sri Lankan military forces made further inroads into LTTE-dominated territory, the number of displaced people in welfare camps exceeded 150 000. Physically and mentally shattered by the war, they needed urgent medical attention.

Twice the Government of Sri Lanka requested funds to provide health care to those affected during the period of the conflict — in September 2008, and again in February 2009.

Doctors, nurses and other health staff were urgently needed to cope with the health requirements of more than 150 000 displaced people. SEARHEF helped to provide the budget for salaries and accommodation for health staff at hospitals and mobile clinics. In three districts, the funds helped build semi-permanent wards and emergency medical care units. Facilities
at other hospitals were also scaled up. WHO supported training for building a mental health workforce at the community level. SEARHEF funds have allowed this to continue. Bandages, antibiotics, emergency medical kits and surgical kits were urgently needed to treat the wounded and sick. As camps got increasingly crowded, chlorine tablets were needed to ensure clean water. Overcrowded hospitals needed equipment, from catheters to mattresses. SEARHEF helped provide medical supplies quickly so that more lives could be saved.

Koshi River floods, Nepal, September 2008

On 18 August, the furious waters of the Koshi river, fed by heavy monsoon rains, burst through the eastern retaining wall of an embankment about 10 kilometres north of the Koshi barrage. The wall of water that gushed out totally inundated Shreepurjavdi and Shreeharipur, and portions of Lohaki and Kusahapaschim in Sunsari District. Thirty-four people died, and 49 000 were displaced. One health sub-post was completely destroyed, and two others suffered partial damage.

On the request of the WHO Representative to Nepal, US$ 325 000 was allocated for the emergency from SEARHEF.

With these funds, essential drugs and supplies were speedily procured and distributed to ensure the health of the people and prevent outbreaks. Rapid assessments of the situation were done to understand the impact of the flood and the gaps that had to be filled for health-care response. The supplies and drugs were provided to rapid response teams that were mobilized by the Ministry of Public Health to provide essential health-care services to the displaced population. Ten mobile clinics were initiated.

Providing assistance to people with different needs in different emergencies, SEARHEF has shown that speedy assistance during an emergency can make a significant difference to the lives of the people.
What is a complex emergency?

The official definition of a complex emergency is “a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single agency and/ or the ongoing United Nations country program.” (IASC, December 1994).

What are some of the complex emergencies in the South-East Asia Region?

The WHO South-East Asia Region has experienced several complex emergencies.

- In Nepal, a ten-year armed Maoist insurgency caused more than 13,000 deaths, and ended with a Peace Agreement in 2006.
- The Democratic Republic of Timor-Leste became an independent republic in 2002, after 25 years of guerilla warfare against Indonesian rule.
- In parts of Indonesia, ethnic and religious tensions have sometimes flared into violence, and have led to long-standing separatist movements.

How is public health affected by complex emergencies?

Health facilities get destroyed, and health services are interrupted by long periods of violence in an area. Health workers are often victims of violence themselves, and with their safety at stake, many emigrate, leaving a huge gap in services. Without basic health services available, more women and children die from preventable diseases, such as diarrhoea, acute respiratory infections, neonatal disorders, and malnutrition and childbirth complications, than from actual violence and injury. Living often for years amidst fear and instability, many people are also seriously affected by mental health problems.

What is “Health as a Bridge for Peace”?

Health is a common need of all people even if divided by conflict. The concept of “Health as a Bridge for Peace” uses health as the common ground to bring people together. It is based on the principle that “shared health concerns can transcend political, economic, social and ethnic divisions among people and between nations”. The phrase was coined by the Pan American Health Organization (PAHO) in the 1980s following a successful immunization campaign in Central America that promoted collaboration between warring guerilla and government forces. Health has since been used as a tool for peace in many conflict zones. However, any such programme should be well-analysed and must understand cultural sensitivities in order to be successful.