



World Health  
Organization

# HEALTH IN EMERGENCIES

Issue No 12, March 2002

## Afghanistan: The Risks of International Psychosocial Risk Management

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The poignant image of six-year old Fardin who has not spoken or walked since his home in Kabul was destroyed last October haunted the media last month (*Guardian*, 12 February 2002). The psychological state of conflict or disaster-affected populations has become a prominent concern in international humanitarian policy. Reports often highlight refugees and internally displaced persons as 'traumatised', 'psychologically scarred' or 'indelibly marked' by their experiences. In complex emergencies mass post-traumatic stress disorder (PTSD) is now expected, so psychosocial programmes are becoming standard features, and psychosocial work a core part of international humanitarian responses. However, there has been surprisingly little analysis of their assumptions or evaluation of their efficacy.

The international psychosocial risk model derives from American social psychology. In summary, the model views distressful experiences as triggering traumatic symptoms causing dysfunctionality leading to abuse/violence, requiring therapeutic intervention to rehabilitate victims and prevent cycles of dysfunctionality. Hence trauma is not merely regarded as a consequence of poverty, war or disasters but as a cause of manifold social problems and therefore an obstacle to future peace and development. These psychosocial perspectives are no longer confined to mental health work but are being adopted in international security and development strategies. Development, for example, is being reconceptualised in therapeutic terms with the psychosocial functionalist notion of well-being displacing material prosperity as its goal.

This does not mean that there are no mental health issues that need to be addressed in Afghanistan or other complex emergencies, as the case of Fardin illustrates. Indeed, Afghanistan's people have a long history of suffering. Long years of war and displacement have undoubtedly impacted on the health status, and the mental health status, of the population. But caution is needed. A professional approach taking into consideration the lessons learnt so far must be identified as a basis for mental health interventions.

Psychosocial risk analysis assumes universal vulnerability and it concentrates on environmental risk factors which are used to estimate trauma. Applying risk analysis, conflict or disaster-affected populations are projected as suffering from mass trauma and psychosocial dysfunctionality. For example, in Afghanistan 5 million of its 23.5 million population are estimated as 'very likely to be affected by psychosocial distress'.

Projections of mass trauma, though, do not sufficiently take into account how distressful experiences are mediated. The phenomenon of PTSD (Post-Traumatic Stress Disorder) for instance, is specific, not universal. Personal, political, social and military circumstances all mediate distressful experiences and influence whether individuals suffer trauma symptoms. Most survivors continue to function effectively irrespective of any symptoms of trauma (Summerfield, 1999). Normal adaptive distress symptoms should not be confused with clinical conditions requiring treatment. Unfortunately, to the extent that international intervention does take into account varying individual susceptibility to stress, it appears to be based on stereotypical notions of vulnerability. Typically international trauma programmes concentrate on women and children rather than men, irrespective of their relative exposure to distress.

Any forthcoming "psychosocial" intervention in Afghanistan should heed experience of the Kosovo crisis where the provision of counselling programmes seemed to reflect aid donor priorities rather than the concerns of refugees. Trauma experts question the effectiveness of

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## MENTAL HEALTH AND EMERGENCIES

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counselling when security and existential problems have still to be resolved. Furthermore, in the Kosovo crisis, the assistance that beneficiaries most appreciated after the fulfillment of physical needs of water, food, shelter and medical support were the tracing and message services. Yet, in certain camps in Albania some international NGOs were offering counselling even before tents had been put up. This will be a critical issue in Afghanistan where the population faces acute existential problems, notably malnutrition, a significant disease burden and high maternal and infant mortality rates. Their fears are not dysfunctional: they are rational reactions to the on-going precariousness of their lives reflected in one of the lowest life expectancies in the world. Tackling their clear physical needs is a prerequisite for alleviating mental distress and humanitarian priorities should not become muddled.

Kosovo refugees seemed receptive to psychosocial programmes, but this receptivity was not unrelated to the significant role international agencies play in any war-affected economy. Where international organisations are far better resourced than local institutions, any connection with them is regarded as an escape from poverty. It made sense for refugees to take up the offer of psychosocial counselling in circumstances where international organisations were systematically promoting the development of a local therapeutic profession, often recruited from the recipients of programmes.

Inappropriate priorities and inappropriate targetting of programmes are not the only problems. The efficacy of various therapeutic strategies is in doubt (Bisson, 2000). Concern has even been raised that debriefing programmes may actually exacerbate symptoms of distress by inadvertently undermining recipients' own coping strategies (Dealh, 1998; Wessely et al., 2000). However, community support is either under-estimated or problematised through the cycles of dysfunctionality thesis which traces the source of crisis to the social psychology of the community itself.

Furthermore, many communities find the notion of psychosocial intervention stigmatising and voyeuristic. This was the case in the Kosovo crisis where aid organisations often had to coat the pill of counselling with the sugar of other activities. More disturbingly, the pathologising of populations as dysfunctional is leading to a problematising of their right to self-government in practice. However, it has long been acknowledged that having a sense of control over one's life is key to recovery.

It is important that WHO has a normative presence in

Afghanistan to conduct professional analysis of the population's health and mental health needs, to make recommendations, and to ensure proper evaluation of psychosocial programmes.

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"They need us only because they are still alive...

...and as they are still alive they have something to teach us."

EHA/EHC 09.01 SPHERE Inter Works

## MENTAL HEALTH AND EMERGENCIES

### Mental health needs in conflict situations

Conflict situations affect health in a variety of ways. These bring with it death, destruction, refugees and internally displaced persons (IDPs) with accompanying impact on mental health. The range of mental health problems commonly associated with conflict situations are depression, anxiety disorders, post traumatic stress disorder, psychotic disorders and adjustment problems. Each age-group - adult, children or elderly - suffer in their own way and solutions can differ. The problems faced by women can vary from those of men. For refugees and IDPs problems arise not only due to the direct effect of the trauma but also due to the adjustment problems with respect to new people, cultures, languages.

The prevalence of mental disorders vary immensely within the community depending on the study design and temporal correlation to the traumatic event. Most community studies report that more than 25% of the affected population suffer either one or a combination of mental disorders. These figures are even higher in conflict areas or when the trauma is persisting. It has been estimated that of the 50 million refugees or IDPs, only 23 million were cared for by the UNHCR and the remaining were supporting themselves due to the lack of consensus in definition (Brundtland 2000). The problems of these 'uncared' people are even more complex.

Both the World Health Report 2001 (WHO, 2001a) and the Health Ministers of different countries attending the 54<sup>th</sup> World Health Assembly (WHO, 2001b) have highlighted the mental health needs of refugees, IDPs, women facing domestic violence and sexual exploitation, children and elderly. Project Atlas of the Department of Mental Health and Substance Dependence, WHO, gathered information on mental health resources from 185 WHO Member States and only 28.3% of those countries reported having any mental health programme for refugees (WHO, 2001c). Unfortunately, most of the conflict areas are in the poorest countries of the world which have very low mental health resources and are unable to cater to the mental health needs of the refugees and IDPs at times of war. Thus even this low figure is an over-estimate of the actual fact. The primary aim of WHO in the area of mental health problems associated with conflict, is to develop the mental health resources of the community, without specifying on any trauma affected population. The reason for doing so are that special facilities for refugees or IDPs tend to ignore the mental health problems of the people in the community and any special problems of traumatised

people can be easily treated by well trained mental health professionals.

At WHO, the Department of Mental Health and Substance Dependence co-operates with the Department of Emergency and Humanitarian Action in providing technical expertise in the field of mental health for population in conflict areas. WHO's specific roles in mental health have focused on:

- collecting epidemiological data related to affected population through rapid assessment surveys
- providing assessment instruments and technical guidance to personnel involved in managing mental health problems in conflict affected populations
- integrating mental health care with other health care and building a capacity at primary and community care level to tackle mental health related problems of individuals in the future
- developing monitoring systems to assess improvement in services and outcomes
- compiling evidence for effectiveness of interventions and disseminating the best practice guidelines for the community keeping in mind the issues of cost and cultural acceptability
- promoting mental health through advocacy and working in tandem with other non-governmental organizations or UN agencies.

The focus is not only to look into the immediate mental health problems and manage them but to develop a mental health delivery system based on the country's needs and capacity so that sustained care can be ensured and any future problems can be tackled more easily.

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## MENTAL HEALTH AND EMERGENCIES

### How to address psychosocial reactions to catastrophe

Terrorist attacks, situations of armed conflict and all forms of catastrophe tax our abilities to cope, understand and respond. They also have a major impact on the affected person's health and psychosocial functioning. Over the years, there has been a significant amount of interest in the issues of psychosocial responses to these types of events which has taught us a great deal. Importantly, we should acknowledge that most people, whether directly exposed to the event, or a remote observer, are affected by such a tragedy.

#### What we know

- ♦ Intense emotional reactions in the face of these events are expected and normal.
- ♦ There is a trajectory of responses over time, most often starting early and subsiding within weeks and months. But for some people, the onset of responses may be delayed. In others, the reactions may become long-term leading to considerable disability.
- ♦ Responses will be highly individual in nature, often quite intense and sometimes conflictual. The vast majority of reactions are in the normal range and the intensity will diminish for most people over time without the need for professional help. Support from family and friends is critical. For some, however, the degree of exposure may lead to more serious and prolonged reactions.
- ♦ The range of feelings experienced may be quite broad. People may describe intense feelings of sadness followed by anger. Others may experience fearfulness and hypervigilance to the environment among numerous other reactions.
- ♦ There may be temporary disruptions in normal coping mechanisms for many people and some may go on to develop problems with sleep, nightmares, concentration, intrusive thoughts and a preoccupation with reliving the events. These reactions are generally short-lived but if they persist, professional consultation should be sought.

WHO's Mental Health and Substance Dependence department web site provides: background information on mental health, mental health topics, publications, events and related links.

[http://www.who.int/mental\\_health/index.htm](http://www.who.int/mental_health/index.htm)

#### What can be done

- ♦ Create opportunities for people to talk and share experiences in supportive groups. This is often done best in familiar surroundings such as religious places, schools or community centers.
- ♦ Provide accurate and practical information especially concerning the larger recovery efforts. Special attention to the needs of relief applicants is necessary as relating to the rules and regulations of the relief organizations during the crisis can be overwhelming.
- ♦ Give particular consideration to the needs of special groups such as children, those who have been most intensely exposed or had a history of previous events (exposure to trauma), rescue workers, and people with pre-existing mental health conditions.
- ♦ Children and adolescents will need the support of their caregivers. This support should reflect accurate concerns, and diminish any words or actions that would increase the child or adolescent's anxiety. Caregivers should offer reassurance as to their presence and availability during this time. Exposure to television, movies or print matter that offers too graphic depictions of the destruction or victims should be limited.
- ♦ A percentage of people, as high as 30%, who experience the most direct exposure to the events may go on to develop more serious mental health concerns and should be referred for services if they develop persistent issues.

Overwhelming feelings are to be expected and can stress individuals, communities and nations. There are many actions that can be taken at the level of governments, international NGOs and local groups to appropriately and effectively support victims of such a catastrophe. WHO can provide technical assistance through its network of regional and country offices, several of which have a developed programme to assist in emergency action and disaster relief.

*The full text of this document is available at: [http://www.who.int/mental\\_health/Topic\\_psychosocial\\_reactions/catastrophe.html](http://www.who.int/mental_health/Topic_psychosocial_reactions/catastrophe.html)*

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## MENTAL HEALTH AND EMERGENCIES

### Strengthening community-based mental health services in Kosovo.

The project, Mental health in Kosovo — Strengthening community-based mental health services, began in January 2000. It was developed and implemented by the WHO Regional Office for Europe Emergency and Humanitarian action unit along with the Mental Health and Substance Dependence department of WHO headquarters and funded by the Government of Japan.

At that time numerous NGOs were working in the vague field of “psychosocial” activities, especially focusing on trauma-related aspects. Some of the interventions had a limited impact as they concentrated on providing direct help to families and training for teachers or professionals. Also, a vacuum on mental health legislation characterized the legal frame in Kosovo. The situation required re-focusing on expanding community-based mental health services, the drafting of mental health legislation to support the Kosovo population and coordination.

The project began with the objectives of 1) strengthening management and coordination on Mental Health and Mental Health Policy planning and 2) strengthening and development of psychiatric services and community-based mental health care. This project was developed and implemented with the foundation of community based mental health services as the cornerstone of reconstructing health services after a complex emergency.

The introduction, promotion and pilot implementation of the community-based mental health concept and services in Kosovo had implications on the existing organization of the health care system. The existing system was very institution-oriented, the personnel working in the mental health services had outdated knowledge and their attitude and practice was often violating the basic rights of the patients. Furthermore, the Kosovo community showed stigma and social discrimination towards people with mental disabilities.

The achievement of the objectives of the WHO Mental Health Project in Kosovo required a multidisciplinary approach involving the following:

- Definition of a strategic plan for mental health
- Review and revision of the existing legislation
- Downsizing of existing special psychiatric institutions
- Establishment of pilot community-based mental health services
- Training
- Fight against stigma and discrimination
- Establishment of partnerships

Examples of the achievements towards this multidisciplinary approach included a wide scope of activities. The Mental Health Task Force developed a Strategic Plan which was included into the Kosovo Health Policy. There was also an urgent need to develop a tool that could both protect the human rights of patients, give to doctors the possibility to enforce a treatment when necessary and facilitate the implementation of the reform strategy. In response, a working group including WHO, drafted a law on forced mental health treatment.

WHO, in collaboration with UNICEF, worked on coordination of NGO projects toward community-oriented interventions. Pilot community mental health services providing home care, outreach teams and income-generating activities were established throughout Kosovo. Training initiatives were undertaken for mental health staff, nurses, general practitioners and detention centre personnel.

This project has worked with the active involvement of the community, to provide sustainable services and redevelop the general mental health services, that are useful for the whole population and not any special groups.

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### Providing tools for mental health in an emergency situation

The Mental Health and Substance Dependence department along with the Emergency and Humanitarian Action department can provide :

- Technical material for a rapid assessment of the situation.
- Audio-visual material for training of health professionals.
- Contacts of nearest collaborating centres (if any), who may be in a position to intervene quickly.
- Training manuals for health workers in the field of mental health care.
- Information on integrating mental health needs with other emergency needs.
- Assist in setting up mental health services including substance dependence facilities.
- Information on the type of community care facilities that may benefit the long-term mental health and substance dependence needs of the population.
- Advice on essential psychotropic drugs.
- Advice on setting up monitoring facilities.



## MENTAL HEALTH AND EMERGENCIES

### Breaking the vicious circle

The reactions of people caught in disasters are normal reactions to extraordinary situations. However, the suffering created by these events may cause psychosocial dysfunction, new instability, new vulnerabilities and new hazards. This vicious circle has self-evident impact on the processes of individual and collective healing, reconstruction and peace. To break it is an enormous and complex task. The fact that mental health in disasters is much more than just a psychiatric concern cannot detract from WHO's responsibility to address it. There is a need to better understand the problem, while at the same time respond to the best of our ability. Therefore, WHO sees its role in this area as normative as well as operational. In-House and external collaborations are needed to cover a vast range of topics that go from the specific vulnerability of mental patients in disasters to wider aspects of social risk and collective vulnerability. There is ample need for consolidation of knowledge, more research, greater consensus on policies, codes of conduct and technical guidelines and capacity building for WHO to assist member states and operational partners in this area.

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### Some useful web sites:

*Centre for Addiction and Mental Health, Toronto, Canada*  
<http://www.camh.net>

*Center for Psychiatric Rehabilitation, Boston University*  
[www.bu.edu/sarpsych/](http://www.bu.edu/sarpsych/)

*The Center for Mental Health Services' Knowledge Exchange Network (KEN)*  
[www.mentalhealth.org/](http://www.mentalhealth.org/)

*International Network of the Practices of Fight against Social Exclusion*  
[www.exclusion.net](http://www.exclusion.net)

*International Network of International Non-governmental Organizations Concerned with Mental Health and Substance Abuse Problems (INMH)* [www.mcgill.ca/douglas/fdg/inmh/](http://www.mcgill.ca/douglas/fdg/inmh/)

*WHO Mental Health Bulletin*  
[www.whomsa.org/it](http://www.whomsa.org/it)

*World Health Organization publications*  
*Mental Health*  
<http://www.who.int/dsa/cat98/men8.htm#Mental%20Health%20of%20Refugees>

The Mental Health and Substance Dependence Department and the Emergency and Humanitarian Action Department are working closely in the area of Mental Health and Emergencies. This newsletter is a product of that close collaboration.

### Strategies for addressing the mental health needs of refugees and displaced populations

"...Of today's 50 million refugees or displaced, some 5 million represent the chronically mentally ill. They were either ill prior to the war or they were seriously traumatised as a consequence of the war; they would need specialized care if it were available. Another 5 million people suffer from psychosocial dysfunctioning affecting their day to day lives and that of their community.

To address the mental health needs of such large populations, we need definite strategies and plans. Ad hoc arrangements and improvisations in response to each emergency will no longer be acceptable. Specific management ability, strong field experience and evidence based approaches are required.

Given the magnitude of the problem, the limited funding, the fact that the majority of the refugees' reactions are the expected reactions to an extraordinarily abnormal situation, individual psychiatric care has a limited impact and is not realistic.

WHO strongly recommends the establishment of community-based mental health care from emergency through reconstruction. Earliest integration of mental health within the public health care system available in camps and national services is the most efficient, and cost-effective strategy. The concerned communities must be mobilized and actively involved to decrease psychiatric morbidity and increase sustainability.

Projects must be holistic, seek multisectoral cooperation, be sensitive to gender, culture and context; they have to take into account the aggravated poverty, the deepened dependency of people and the feeling of loss of dignity due to the ongoing human rights violations. Ethics, and financial equity - locally and internationally - should be inextricably linked to every action...

"...It is our moral and professional obligation to provide the resources, to preserve mental health, restore dignity, and create hope and self-confidence for fellow human-beings."

*Excerpts from WHO Director General, Dr GroHarlem Brundtland's speech at the International Consultation on Mental Health of Refugees and Displaced Populations in Conflict and Post-Conflict situations. Geneva, October 2000*

*The full text of this speech is available at: [http://www.who.int/director-general/speeches/2000/english/20001023\\_mental\\_health.html](http://www.who.int/director-general/speeches/2000/english/20001023_mental_health.html)*





## SPOTLIGHT ON AFGHANISTAN

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The experience from other countries emerging from long conflicts is that rebuilding a health system is a long and daunting endeavour, requiring the concerted and continued efforts of national and international actors. It will be costly. The payoff, however, will not only be the improvement of the health status of Afghans. A viable health system, able to meet basic needs, will contribute to making Afghanistan's transition to peace more solid. It will also boost socio-economic development, through the impact on the health status and the injection of substantial resources in the cash-stripped economy of the country. As the report from the Commission concludes, one dollar invested in health not only contributes to saving lives but also produces an economic gain. After so many years of predicament and suffering, Afghans deserve such support.

### Endnotes

<sup>1</sup> "one of the world's orphaned conflicts, the ones that the West, selective and promiscuous in its attention, happens to ignore in favour of Yugoslavia"

<sup>2</sup> The NA was led by the WB, ADB and UNDP. As for the health sector, WB, WHO and UNICEF participated in the exercise.

<sup>3</sup> The data refer to different periods between 1990 and now

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## A preliminary assessment of the pharmaceutical situation in Afghanistan

A WHO team comprising staff members from the Department of Emergency and Humanitarian Action (WHO Headquarters, Geneva), the Department of Essential Drugs and Medicines Policy (WHO Headquarters, Geneva) and Essential Drugs and Biologicals (WHO Regional Office for Eastern Mediterranean, Cairo) conducted a preliminary assessment of the pharmaceutical situation in Afghanistan in January 2002.

Key sites of the pharmaceutical sector in Kabul, such as the drug manufacturing plant, warehouses and the Quality Control Laboratory were visited. The team was impressed by their counter-parts in the Ministry of Public Health, who, after serving for many years under difficult conditions and with extremely limited resources, are still active showing great professional commitment and profound dedication to their work.

The overall pharmaceutical situation in Afghanistan has deteriorated dramatically. The health infrastructure is seriously damaged; some buildings have been completely destroyed, others have broken windows, missing electrical wiring, etc. thus making it very difficult for the staff to maintain professional standards. Lack of essential drugs is very common in public health facilities, expensive brand-named medicines available in private pharmacies remain unaffordable for most Afghans. In addition there is wide spread consumption of low quality and ineffective medicines procured both in public and private facilities. However recent events provoked a huge influx of drug donations in the country, temporarily alleviating the recurrent shortages.

Major technical and financial assistance will be required to develop pharmaceutical systems offering an appropriate level of services critically needed by the population. WHO has proposed a US\$ 25 million budget for the 1<sup>st</sup> year to the international community, which would allow the establishment of medical stores at the central and provincial levels supplying safe essential drugs to the Afghans in Kabul, in the provinces and also in remote areas where the majority of the population lives.

Several specific activities have been identified for immediate implementation. The main criteria for selection were a) importance as foundations for sustainable development of the sector, b) bringing together the key-

players under the overall guidance of the Ministry of Public Health, c) ability to initiate immediately moving from assessment to action without undue delay, d) independence from need for substantial additional funding. The identified areas for immediate action include:

- Appoint essential drugs focal point in WHO Office in Kabul;
- Develop national guidelines for drug donations;
- Review and update the national list of essential drugs;
- Train key staff;
- Initiate the national drug policy development process;
- Establish a mechanism for testing of drug samples in the region.

Building up the pharmaceutical sector will take years and requires long term commitment of any partner engaging in the country. WHO is committed to work closely with the Government of Afghanistan and coordinate efforts of other United Nations Agencies and Non Governmental Organizations involved in the development of the pharmaceutical sector. For more information please contact C. Chomilier at [chomilier@who.int](mailto:chomilier@who.int)

## Investing in health for economic development

The Commission on Macroeconomics and Health (CMH) recently released its final report. The Commission, chaired by J. Sachs, was set up by WHO in 2000 to examine the links between health and economic development. The central theme of the report is that, in spite of health being key to economic development, little investment actually targets health in the poorest countries. The report argues that extra-spending on health by the rich countries could not only save lives, but also produce important economic gains: the CMH estimates that an investment in health of \$163 billion by 2007 will save 8 million lives by the proposed package of essential interventions (mainly targeting infectious diseases, maternal and child ill-health and nutritional deficiencies) and will bring an economic benefit of \$186 billion. The increased financing would fall on both donor and beneficiary countries, which should commit additional assistance and improve domestic resource mobilization respectively. Partnership with the pharmaceutical industry is also crucial, since the expansion of services requires that low-income countries have access to essential drugs at near-production cost. But the lack of funds is not the only constraint to scaling up effective health interventions: political and administrative commitments on the part of donors and countries are prerequisites for removing organizational bottlenecks in the provision of services. The CMH report recognizes that increased funding also requires stronger leadership,

## New publications catalog available on-line

The Pan American Health Organization (PAHO) new Catalog of Disaster Publications and Information Resources is now available through the Internet. Every print publication since 1980 is available in full-text HTML and in PDF format. The catalog contains a detailed description of all PAHO disaster training materials (books, CD-ROM's, slides and videos) and other sources of information. Browse through the general index for a list of the more than 65 information products on disasters or download the entire catalog in PDF format.

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management capacity and accountability, mainly at the community level or at the close-to-client part of the system.

The report and the background papers prepared during two years of the CMH work point to the increasing body of evidence that a dollar spent on health will bring a better return than any other investment. The challenge is now how to convince foreign policy and finance ministries of the western world that there are also benefits to donor countries to increase aid and target it towards health. As a matter of fact, only five countries meet the target of investing 0.7% of their GDP on development aid, and the richest countries spend less than 0.3%. If the other DAC donors reached the 0.7% target, the volume of aid would more than double<sup>1</sup>

But J. Sachs, the Chairman of the CMH is optimistic: "There has been a watershed in international health and this report is part of the process..... Will the donors rise to the challenge? My answer is yes.... September 11 has raised the awareness of what social collapse in one part of the world can mean for the rest of the world"<sup>2</sup>.

### Endnotes

<sup>1</sup> Morrissey, O.: Introductory Brief. ODI opinions and effective expansion of aid; Overseas Development Institute, [www.odi.org.uk/opinions](http://www.odi.org.uk/opinions), 2002

<sup>2</sup> Creating a healthy global economy; British Medical Journal, 324, 12, 2002

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## WORLD HEALTH NEWS

### Assessing the health situation in West Timor refugee camps

*West Timor:* The independence of East Timor in August 1999 led to an influx of 290,000 refugees into West Timor, already one of the poorest provinces in Indonesia, and least able to cope with increased demands on health services.

In September 2000, the militia murder of three international staff in Atambua (North of West Timor) prompted all UN agencies, including WHO, to evacuate their international personnel from West Timor. Since that time, as a result of UN security regulations, no UN staff were allowed to enter this area. All WHO/EHA activities in West Timor were interrupted in September 2000.

To provide closer support to the local health authorities as well as to carry out an appropriate implementation and follow-up of the health activities in West Timor, WHO reopened the WHO office in Kupang the 1<sup>st</sup> of February 2002. All WHO staff in West Timor, including the national consultants, come from Kupang in order to respect the UN security regulation.

The planned WHO activities during 2002 are focused on assessing the current health situation in the refugee camps as well as assessing the current situation of the disease surveillance system, social and mental health problems and immunization programs.

In order to collect updated information about the health situation in the refugee camps in West Timor as well as to know the general health situation in the province, a joint Jakarta-Dili WHO mission visited Kupang in West Timor (NTT Province) from the 11<sup>th</sup> to the 15<sup>th</sup> of February, 2002.

The recommendations from this mission include the establishment of regular health meetings attended by all health humanitarian actors and co-chaired by WHO and the Provincial Health Office as a first step to strengthen and improve coordination mechanisms. In order to prepare a plan of action to simplify and standardize the existing system, a Health Surveillance Working Group should be formed. The emphasis should be on a minimum data set to be collected, analysed and acted upon at each level of the system as well as on training of staff to make the system operational, including the development of quality assurance mechanisms for completeness, accuracy and timeliness. Also, a WHO Health Emergency Library Kit should be located in the WHO Office in Kupang for use by all local health service providers.

*The full text of this mission report is available at:*  
<http://www.who.int/disasters/repo/7649.doc>

### Sharing information in humanitarian crises

The Symposium on Best Practices in Humanitarian Information Exchange was held in Geneva between February 5<sup>th</sup> and 8<sup>th</sup>, 2002. The symposium, organized by the United Nations Office for the Coordination of Humanitarian Affairs, convened around 250 participants, including UN agencies, NGOs, government representatives, academics and the private sector, to discuss lessons learned in the management and coordination of humanitarian information, to identify best practices in this field and promote them.

The agenda of the event was comprehensive: during the first two days working groups debated field-based web sites, the use of new technologies and approaches in information management for humanitarian crises and database applications for field coordination and humanitarian information centres. In the following two days, panels presented the achievements and challenges in humanitarian information management, the ways to improve information sharing between relief agencies, information for humanitarian coordination and operational decision-making, and the importance of common standards and guidelines for data quality and information integrity. The agenda, keynote speeches, presentations and participant list are available on ReliefWeb (<http://www.reliefweb.int>). The symposium ended with a statement<sup>1</sup>, which covers main principles of humanitarian information management and exchange, key issues to be addressed when designing information systems, best practices derived from lessons learned and recommendations for action to resolve outstanding issues. Progress on these recommendations will be posted on ReliefWeb, submitted to the Inter-Agency Standing Committee (IASC) and will become the subject of the next symposium.

#### Endnotes

<sup>1</sup> Final statement available at [http://www.reliefweb.int/symposium/bp\\_statement.html](http://www.reliefweb.int/symposium/bp_statement.html)

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EHA's web site 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/disasters>

## Responding to requests for the Emergency Health Library Kit

EHA has selected key guidelines on best public health practices for humanitarian assistance and disaster reduction, composing the Emergency Health Library Kit (EHLK), intended to provide technical guidance to agencies operating in the field.

The 140 documents, guidelines and reference manuals are produced by WHO, other UN organizations, and external publishers. Summaries of the contents of EHLK with detailed information can be accessed at the web address: <http://www.who.int/disasters>.

Upon request the EHLK can be provided to agencies working in the field during emergencies. The cost of each Kit amounts to US\$ 2300, transportation costs excluded.

108 Emergency Health Library Kits have been distributed world-wide, since 1998. In January and February of this year 10 kits were distributed to Burundi, Kenya, Republic of Congo, Rwanda, Somalia, Sudan, and the Democratic Republic of Congo (Goma).

In response to requests from our partners in Russian-speaking countries and in order to increase the emergency capacity building of the Central Asian Republic countries, WHO is investigating the options for translating publications into Russian. The following is a selection of the books WHO is interested in translating: Public Health Action in emergencies caused by Epidemics, Rapid Health Assessment Protocols for emergencies, Guidelines for Assessing Disaster Preparedness in the Health Sector, Mental Health Services in Disasters, Epidemic Diarrhoeal Diseases Preparedness and Response, The Management of Nutrition in Major Emergencies, Assessing the Health Consequences of Major Chemical Incidents-Epidemiological Approaches and Health Services Organization in the Event of Disaster. The project is a joint initiative of the Emergency and Humanitarian Action Department at regional and headquarters level. The translated books will be distributed through the WHO country offices to the end users: MOH, regional and local health Authorities, the national/regional/local structures for emergency management, as well as universities and medical schools.

Emergency Health Library Kits have been distributed to French-speaking countries. A project proposal has been prepared to compile a French version especially for the African Region.

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## Reaching out to users

EHA's protocols for carrying out rapid health assessments in the aftermath of emergencies are being translated into Arabic. The protocols are contained in the 1999 book "Rapid Health Assessment Protocols for Emergencies", which has been published by WHO in both English and Spanish. The Arabic translation of the book is being prepared by the WHO Eastern Mediterranean Region's Centre for Environmental Health Activities (CEHA) in Amman, Jordan. It is expected to be published by the end of the year.

Versions of the book have also been produced under licence by other publishers in Chinese (by the People's Medical Publishing House, Beijing) and in Turkish (by the Turkish Medical Association in Ankara). The rapid health assessment protocols are also available in Vietnamese. WHO welcomes requests to translate and publish this book in other languages (contact [pubrights@who.int](mailto:pubrights@who.int)).

## Health emergency training in French-speaking Africa

Health professionals working in emergencies last month attended training on Health Emergencies in Large Populations (HELP) in Lomé, Togo.

The HELP course was jointly created by the International Committee of the Red Cross (ICRC), the World Health Organization (WHO) and the University of Geneva seventeen years ago to train health workers operating in emergency situations. More than 1000 health workers have been trained through over 50 HELP courses throughout the world. The courses have been conducted in English and Spanish and this year's course in Togo was the first delivered in French.

The HELP course is made up of two weeks' training in public health in emergencies and one-week training focuses on health, ethics, law and politics.

Dr. Daniel Koch, HELP course Co-ordinator, ICRC said that the course had been very well received by participants. Mr. Y Chellouche, WHO focal point for Emergency and Humanitarian Action in Brazzaville said that "the training was very useful. The modules on food security, water and environmental hygiene, public health in emergency and armed conflicts were especially useful." Mr. Chellouche added: "Sharing the basic information will be among my priorities."

The organisers plan five more HELP courses in 2002. Details can be obtained from the EHA website: <http://www.who.int/disasters>



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*Production of this newsletter has been made possible by the support of the Italian Government.*

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