

WORLD HEALTH ORGANIZATION, REGIONAL OFFICE FOR EUROPE
8, Scherfigsvej, DK-2100, Copenhagen, DENMARK
Phone: +45 39 17 13 39 Fax: +45 39 17 18 56
Electronic mail: VVE@who.dk

and

INSTITUTE FOR RESOURCE AND SECURITY STUDIES
27 Ellsworth Avenue, Cambridge, Massachusetts 02139, USA
Phone: (617) 491-5177 Fax: (617) 491-6904
Email: info@irss-usa.org
Web: www.irss-usa.org

**APPLICATION OF THE
PEACE THROUGH HEALTH APPROACH
IN THE NORTH CAUCASUS**

Report of an Inter-Agency Consultation

Moscow, 4-5 April 2000

Prepared by
Dr. Paula Gutlove

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Note: a **Health as a Bridge for Peace Briefing Manual** was prepared for this meeting and is available upon request from WHO/EURO or IRSS.

I. SUMMARY

The World Health Organization (WHO) and the Institute for Resource and Security Studies (IRSS) convened an informal, inter-agency "Peace Through Health" consultation on 4-5 April 2000. Hosted by the Russian Red Cross in their Moscow office, the consultation brought together 24 people representing a variety of international, regional and local agencies and NGOs concerned with health-related humanitarian assistance in the North Caucasus. A list of participants in the consultation is attached as Appendix A.

The main objective of the consultation was to bring together diverse actors to explore how humanitarian assistance programs could provide health benefits to target populations while also facilitating and promoting peace building, social reconstruction and, in the longer term, the development of democratic, stable society. At the organizational level, this consultation was intended to help the relevant agencies to coordinate their activities and utilize a Peace Through Health (PTH) approach.

The PTH approach utilizes a shared concern for public health as an opportunity to deliver health care while engaging in social reconstruction and community reconciliation programs. The most fundamental starting point for any PTH intervention is that it must be grounded in the socio-political conditions of the area in which the intervention will take place.

Discussion at the meeting explored the roles of the health and emergency assistance communities in promoting social reconstruction. An overview of related PTH efforts elsewhere was provided, highlighting initiatives by WHO and IRSS in the Balkans. Participants had the opportunity to present their organization's relevant initiatives, and to discuss the implications of PTH for their work. The group generated 12 basic "PTH Principles For Action" which could usefully be applied to health-related humanitarian assistance in the North Caucasus. Discussions at the meeting are reported in more detail below. A meeting agenda is provided in Appendix B.

This consultation was intended to be an initial step toward an ongoing Peace Through Health process in the North Caucasus. Participants agreed that an Inter-Agency Task Force should be formed to follow up this consultation. This Task Force would have three primary functions:

1. to promote PTH concepts and principles, through such vehicles as Web sites, professional journals, professional meetings, promotional notices, etc.;
2. to create a PTH database for relevant activities in specific regions; and
3. to promote a PTH approach whereby existing and new health-related efforts can maximize their effectiveness.

It is intended that the Inter-Agency Task Force will work synergistically with other bodies that focus on the delivery of health care or humanitarian assistance, and with bodies that are coordinating programs for the promotion of democratic civil society, social reconstruction and community reconciliation.

II. PEACE THROUGH HEALTH - STRATEGY AND PRINCIPLES

Health professionals have an intimate association with the people who have suffered mentally and physically from armed conflicts. They are often well educated, and have stature and access to a wide range of community groups. Health professionals can create a bridge of peace between conflicting communities, whereby delivery of health care can become a common objective and a binding commitment for continued cooperation. Reconciliation after the trauma of war requires a healing process whereby relationships, both individual and community-wide, can be restored.

Involvement of health professionals from different sides of a conflict in the delivery of health care can be a model for collaborative action, and can create the long-term community involvement that is essential for sustainable peace. In a post-conflict community, the health sector is often one of the few sectors to be aided by international and NGO assistance. This aid can provide options for communication, transport, technology transfer and educational support that are otherwise unavailable.¹ Furthermore, international medical organizations have experience in building bridges between medical communities in developing and developed countries, North and South, East and West. The delivery of health care has been the basis for significant cooperation between parties that have been divided by violence. International agencies, notably WHO and UNICEF, have pioneered the promotion of humanitarian cease-fires for pediatric immunizations and other public health emergencies. WHO has demonstrated the potential for health to be a unifying influence on a longer-term basis, through research/action programs, sustained inoculation campaigns, and health education programs in conflict-torn areas.²

In recognition of the special role that health professionals can play, IRSS³ launched the Health Bridges for Peace (HBP) project in 1996. The purpose of the project is to utilize a

¹ A Health to Peace Handbook, War and Health Program of McMaster University, Hamilton, Ontario, Canada, 1996, page 5.

² For more information about the evolution of PTH programs and activities please see "Health As A Bridge To Peace: The role of health professionals in conflict management and community reconciliation", by Dr. Paula Gutlove, in Report from the Global Symposium on Violence and Health, October 1999, WHO Centre for Health Development, Kobe, Japan, June 2000.

³ The Institute for Resource and Security Studies (IRSS) is an independent, non-profit corporation, founded in 1984 to promote international security and sustainable use of natural resources. This objective is pursued through technical and policy analysis and public education. To complement its analytic and educational work, IRSS

shared concern, namely the restoration of public health, as a vehicle to convene, engage, and train health care professionals in conflict management and community reconciliation techniques. Also, once these professionals are trained, they are assisted in designing and implementing inter-communal activities that integrate community reconciliation and conflict prevention strategies into health care delivery. The first field program in the Health Bridges for Peace project has operated in the former Yugoslavia since 1997, when local physicians formed the Medical Network for Social Reconstruction in the former Yugoslavia. The second Health Bridges for Peace field program was initiated in the North Caucasus in November 1998, when WHO and IRSS brought together Chechen, Ingush, Ossetian and Russian health professionals in South Russia.⁴ At this meeting the Medical Alliance for Peace through Health in the North Caucasus was born.

Experience with HBP programs in the former Yugoslavia and the North Caucasus has confirmed the enormous potential for using health as a means to build a culture of peace in post-conflict areas. It has also provided important lessons about integrating health initiatives with community reconciliation in a systematic and sustainable manner, as follows:

- A Health Bridges program should be guided by a broadly representative group of indigenous personnel. Only the local people can identify the crucial health needs of their communities. Moreover, important resources for understanding and transforming conflict can be found within the culture from which a conflict has emerged. Wherever possible, participants should be involved in developing their own training programs.
- The greater the ownership local groups have of a training program, the greater is the likelihood that they will find ways to use it and sustain it.
- In order for training to have a long-term impact, it must be embedded in a structure that has the potential for long-term sustainability. Thus, the organizational development of the Medical Network and the Medical Alliance is in each case crucial to the success of the program.
- Setting up channels for ongoing communication and information exchange among a range of parties is essential for preserving the gains made at meetings and training sessions. For example, at times when direct communications were impossible, members of the Medical Network have creatively sent messages and medical aid through “third” parties. These symbolic and substantive acts were crucial to

engages in public participation, dialogue facilitation and conflict management through its International Conflict Management Program. This program works with people of diverse perspectives and interests, to improve communication, build understanding, promote cooperation, and develop new models for sustainable community reconstruction and reconciliation. IRSS designs and convenes workshops and training sessions to facilitate dialogue, promote collaborative problem-solving, encourage cooperative actions, and develop inter-communal networks.

⁴ Paula Gutlove, Health as a Bridge for Peace in the North Caucasus: a Workshop for Health Professionals in Pyatigorsk, Russia, 29 October - 2 November 1998, World Health Organization, Copenhagen, and Institute for Resource and Security Studies, Cambridge, Massachusetts, December 1998.

maintaining the gains in trust and human connection that each meeting of the Network has achieved, and were ultimately essential to the survival of the Network.

- A Health Bridge program is not sustainable or maximally effective unless it relates to other organizations and actors. Thus, the local medical networks are able to grow and gain stability by maintaining communication links with a range of relevant humanitarian and development agencies and NGOs, and with government and intergovernmental agencies. The most important link is probably with the WHO.
- Ongoing program evaluation and the ability to change in response to critical evaluation are essential to the efficiency and sustainability of any training program. Also, the program must be able to adapt to a changing political landscape.

The combined experiences of WHO and IRSS with the Health Bridges for Peace Project and PTH field programs has provided further lessons that could be guiding principles for future HBP and PTH programs.⁵ These principles include:

- Health must always be the primary concern, even though PTH programs seek to expand their impact wider than the immediate health care delivery program in question.
- Each PTH program must be tailored to respond to the cultural, economic and socio-political conditions of the region in which it will be implemented.
- PTH programs must place a very high priority on working with parties from all sides of a conflict, not just with one group. This means that assistance is not limited to "victims" only, but is provided to all sides who have suffered and are in need of assistance.
- PTH programs must be based on cooperation and collaboration among government, inter-government and non-government organizations, and between the health sector and other sectors. Important goals of PTH programs are to provide opportunities for cooperation, and to facilitate its growth.
- It is important in PTH programs to maintain a long-term view, and to aim for program sustainability wherever possible. It usually takes time for the true impact of PTH programs to become apparent.

III. PTH PROGRAMS IN FORMER YUGOSLAVIA

Two PTH initiatives in the former Yugoslavia were described, to illustrate the ways in which a PTH program can operate in the field. Dr. Stephane Vandam (Desk Officer, WHO/EURO) described the work of the WHO PTH program in Croatia and Bosnia, and Dr. Gutlove described the work of the Medical Network for Social Reconstruction in the Former Yugoslavia.

⁵ For simplicity, principles are articulated here with reference to PTH programs, but these principles apply equally to HBP programs.

A. WHO Peace Through Health Program

For more information about this program please see a case study prepared by the WHO Field Team in Bosnia and Herzegovina.⁶

The Peace Through Health programme in Bosnia and Herzegovina (BiH) was a collaborative endeavour of the World Health Organization and the Department for International Development (DfID) of the United Kingdom. PTH integrates WHO's health sector development work and DfID's conflict resolution mandate. Through a PTH approach, a concerted effort is made to address fundamental obstacles to peace through health sector development. This is in keeping with WHO's mandate to address issues of public health with neutrality, impartiality and humanity.

The PTH program was designed to address key barriers to the formation of a democratic civil society: polarization, manipulation of information, discrimination, centralization of authority and power, isolation, and violence. As factors at the root of the Bosnian conflict, these behaviours will continue to predispose BiH to renewed conflict unless addressed. They will continue to promote a systematic transfer and augmentation of prejudices to future generations. Consequently, these factors prevent or hinder the achievement of real health gains. Each of them is present in the health sector and/or has an adverse influence on health and health care delivery.

The PTH strategy was integrated horizontally through all WHO BiH programs. Through a network of field offices, WHO was able to implement a wide range of activities at various levels of the health system. Activities sought to address priorities in the health sector through strategies which contributed to peace-building processes.

The PTH program sought to catalyse and strengthen peace processes through the integration of peace building and reconciliation into health development. It was intended to address structural and social aspects of peace building (see below). Concrete activities implemented by WHO contributed to group and institution building for viable post-war reconstruction, while relationship building fostered by the WHO staff facilitated community reconciliation.

In the program, three types of peace building were identified as necessary for the successful transformation to a peace system: political, structural and social.

1. Political peace building

Political peace building is the formation of agreements and political arrangements that provide the overall context within which to understand the relationships of the various parties and

⁶ WHO/DfID Peace Through Health Programme, a case study prepared by the WHO Field Team in Bosnia and Herzegovina, published by WHO/EURO, September 1998.

their resources. It is about building a legal infrastructure that can address political needs and manage the boundaries of a peace system.

Examples of this approach include: regular meetings of the Ministers of Health (or the top authorities in the health sector); communication and collaboration between public health directors; a "Health for All" national conference; common pharmaceutical guidelines; and draft legislation.

1. Structural peace building

Structural peace building encompasses activities which create structures – systems of behaviour, institutions, concerted actions – that support the embodiment or implementation of a peace culture.

Examples of this approach include: an inter-group epidemiology workshop; a continuing education centre and lecture series; Poliomyelitis National Immunization Days; and a National Tuberculosis Program.

2. Social peace building

Social peace building addresses feelings, attitudes, opinions, beliefs, values and skills as they are held and shared between peoples, individually and in groups. It is about building a human infrastructure of people who are committed to engendering a new culture, a “peace culture”, within the fabric of communal and intercommunal life.

Examples of this approach include: a youth leadership training summer camp; facilitation of regular contact between health professionals; and a mental health photography exhibit.

B. Medical Network for Social Reconstruction in the Former Yugoslavia

The Medical Network was initiated in 1997 to promote the resolution of existing conflicts and the prevention of future conflicts in the former Yugoslavia. It was founded upon two major beliefs. First, violent conflict and war are the ultimate threat to public health. Second, the medical community has a unique and crucial role to play in promoting a healthy society, not only by mending the physical and psychological wounds of individuals but also by rebuilding structures for public health care and creating bridges for community reconstruction and social reconciliation. To these ends, the Medical Network aims to promote dialogue, cooperation, personal contacts, practical solutions and the renewal of relationships in its region. Acting on these beliefs, the Medical Network runs periodic training workshops, conducts a range of inter-communal health care projects, and convenes annual conferences.

Medical Network conferences serve to promote professional and organizational development while promoting the social reconstruction of the region. Each conference generally consists of plenary sessions and workshops, through which participants work together to examine and advance the role of health professionals in reconciliation, reconstruction and conflict prevention in former Yugoslavia. There are opportunities for exchange of knowledge on

substantive issues, development of training programs for use by medical professionals to prevent conflict and encourage reconciliation, and organizational development of the Medical Network. The exchange of knowledge on substantive issues covers practical issues facing health professionals in a post-war situation, in categories such as: health care; social reconstruction and community reconciliation; refugees and resettlement; youth and the building of hope for the future; psycho-social support; and the development of civil society.

Annual conferences provide important opportunities for relationship building, across conflict divides, among the participants. These opportunities are built upon through training workshops designed specifically to promote the role of health professionals in conflict prevention and community reconciliation. In April 1998, with assistance from the WHO office in Bosnia, the Medical Network held its annual conference in Sarajevo. More than 100 health professionals, from the former Yugoslavia and internationally, convened to explore the role of health professionals in reconciliation, social reconstruction and conflict prevention.⁷ In April 1999 the annual conference was held in Ohrid, the Former Yugoslav Republic of Macedonia.⁸ In view of the violence in the region at that time, the conference focussed on training Kosovar and Macedonian health care providers in three areas: treatment of traumatic stress; the use of volunteers in social reconstruction; and the integration of conflict management and community reconciliation with trauma recovery.

In May 2000 the Medical Network held its most ambitious conference to date in Gracanica, Bosnia. Gracanica, in north-east Bosnia, falls within both the Federation of Bosnia-Herzegovina and the Serbian Republic. It is also part of a wider Bosnia-Croatia-Serbia triangle. Since 1998, Network members from Slovenia, Bosnia, Serbia and Croatia have cooperated on a training program in Gracanica, integrating trauma recovery with community reconciliation and developing a network of volunteers to assist in social reconstruction. The May 2000 conference provided training in: medical assistance to handicapped children; psychosocial treatment for war-affected people, including refugees and veterans; and the integration of trauma recovery with community reconciliation. Three Chechen colleagues from the Medical Alliance for Peace Through Health in the North Caucasus attended the meeting.

The Network has a 12-member Contact Group that serves as its steering committee. This Contact Group meets every six months, has email and fax communication on a regular basis, and leads the Network as it engages in cooperative medical projects that cross conflict lines. Examples of Network inter-communal health care programs include:

⁷ Paula Gutlove, Reconciliation, Social Reconstruction and Conflict Prevention: The Role of Health Professionals, report on an International Conference, 23-26 April, 1998, Sarajevo, Bosnia, Medical Network for Social Reconstruction, Sarajevo, November 1998.

⁸ Paula Gutlove, The Medical Network as a Bridge to Health and Peace, report on an International Seminar and Training Workshops, 27-30 May 1999, Ohrid, Macedonia, Medical Network for Social Reconstruction in the Former Yugoslavia, Ohrid, Macedonia, September 1999.

- Psychiatrists and psychologists from Slovenia, Bosnia and Croatia have helped to set up inter-ethnic counselling and reconciliation programs in their own republics and have worked together with colleagues in Bosnia, Kosovo, Montenegro and Macedonia to set up similar programs there.
- Training, in psychosocial support for traumatic stress and in the use of volunteers in psychosocial programs, is being carried out throughout the region by a core of Network members from Slovenia and Croatia.
- The Network has established an electronic communications linkage that functions for long-range planning and as an emergency alert system.
- Network members from Slovenia and Croatia collected hospital equipment from West European sources and, with IFOR military escort, brought it to two hospitals, one in the Bosniac Federation and the other in the Republika Srpska.
- The Network plans to publish a bi-monthly Network Newsletter and establish a Mobile Medical Library.

IV. PTH IN THE NORTH CAUCASUS: MEDICAL ALLIANCE FOR PEACE THROUGH HEALTH IN THE NORTH CAUCASUS

Dr. Vladimir Verbitski, Desk Officer, WHO/EURO, presented the work of the Medical Alliance for Peace through Health in the North Caucasus. To supplement his presentation, Dr Luyba Archakova, director of the Agency for Rehabilitation and Development in Chechnya and Ingushetia, and an active organizer of the Medical Alliance, added comments from her recent experiences on the ground.

In April 1998, physicians from Chechnya were guests at a Medical Network conference in Sarajevo. This stirred an interest in the North Caucasus for a Health Bridges for Peace field program, and a request to IRSS for assistance. In October 1998, IRSS convened and facilitated a workshop at which the Medical Alliance for Peace through Health in the North Caucasus (Medical Alliance) was born. The five-day workshop took place in Pyatigorsk, Russia, from 29 October to 2 November 1998. The workshop brought together 21 health professionals from Chechnya, North Ossetia, and the Stavropol and Krasnodar regions of Southern Russia. Health professionals from Ingushetia were scheduled to attend but were unable to travel into Southern Russia for political reasons at the last minute. Workshop participants included ministers of health, heads of hospitals, directors of community health facilities, and a range of clinicians and administrators with significant public health responsibilities.

The workshop was organized through local and international networking and cooperation. The primary organizers on the local level were the Netherlands Relief Committee for Chechnya (RCC) and the Association for the Protection of the Rights of Refugees and Forced Migrants (ADEPT). The OSCE Assistance Group in Chechnya provided logistical

support. WHO provided information about potential participants, as well as invaluable program assistance, before and during the workshop.

Workshop participants unanimously agreed to continue their work together and to expand their network to include all ten republics of the North Caucasus. To do this they decided to form the Medical Alliance for Peace through Health in the North Caucasus. The mission of the Medical Alliance is to work collaboratively in the North Caucasus to promote peace through health, engaging in collaborative initiatives that improve physical, mental and social health in the region.

In order to enhance communications within the region, the Medical Alliance made plans to publish a monthly newsletter through the WHO/EURO office in Copenhagen. The Medical Alliance also started planning on a range of cooperative public health programs, including: a regional network on tuberculosis control; cooperative centres for psycho-social rehabilitation; a North Caucasus inter-regional training centre for the prevention of drug addiction; and a cooperative program for prosthetic assistance to amputees in the North Caucasus.

The Medical Alliance had plans to hold its second regional meeting in November 1999, and received support to do this through a generous gift of the Japanese government to the WHO/EURO office. Unfortunately, the instability in the region has put on hold plans to bring the group together in the North Caucasus. As an alternative, some of these funds have been used to support the interagency consultation which is the subject of this report. In addition, these funds have supported the attendance of three representatives of the Medical Alliance at a conference of the Medical Network in the former Yugoslavia, in Gracanica, Bosnia in May 2000. The active involvement of the Chechen participants in the conference, and their information about the situation in their region, provided a moving and dramatic counterbalance for their colleagues in the Balkans. The Chechen participants reported that they learned many lessons about social reconstruction at the conference, and hoped to implement these lessons at home.

V. EMPLOYING PTH TO RESPOND TO REGIONAL NEEDS

Participants in the consultation generated a list of regional health-related needs that could be amenable to a PTH approach. The needs are:

1. Psycho-social assistance, particularly but not only for youths (who need to regain hope for the future and to see a role for themselves in it) and members of the displaced population. Capacity building is essential to cope with the increased need for services.
2. Prevention and treatment of tuberculosis.

3. Support to local health personnel, including capacity building, care for care givers, and networking, particularly information exchange to support mutual learning.
4. Maternal-child health care.
5. Health care for victims of war.
6. Epidemiologic information, particularly in areas where violence makes it difficult or impossible to get accurate information (which is the situation in Chechnya, where it is impossible to safely enter to get information).
7. Improved communication and cooperation between governmental, inter-governmental and non-governmental organizations.
8. Attention to the distribution of aid and humanitarian assistance so that asymmetry in distribution does not fuel existing or new conflicts.

Specific social-political problems in the region were outlined that can be addressed (either directly or indirectly) through a PTH approach, thereby helping to rebuild a post-conflict society. These problems are:

9. Unemployment (especially in Chechnya) and underemployment, with a resultant redundancy of young men and redundancy of professionals (e.g., medical professionals).
10. Lack of infrastructure, causing unmet basic human needs for housing, food, etc. (especially true for Chechnya and the Internally Displaced Population (IDP) in the region).
11. Intra-societal tensions, e.g., conflict between the displaced population and host communities, together with increasing levels of interethnic hostility, discrimination and xenophobia.
12. Militarization of society, including increased availability of weapons and an increasing emphasis in the culture on violence and war.
13. Lack of basic human security, civil justice, and law and order (e.g., kidnapping is commonplace).
14. Corruption on various levels of society.
15. Violence against the most vulnerable members of society, e.g., women and children.

16. Collapse of the family, isolation of the elderly, prevalence of orphaned children, and personal isolation.
17. Marginalization of large segments of society (based on medical and/or psycho-social differences).
18. Fragmentation of society along religious, social, cultural or ethnic lines.

VI. PTH ACTION GUIDELINES

Informed by the basic principles and philosophy of PTH, and the needs of the region, the participants in the consultation worked together to generate 12 PTH Action Guidelines that could guide the development of PTH initiatives in the North Caucasus. These initiatives would involve the application of PTH principles and approaches to a range of health-related programs.

The guidelines are intended to be broadly applicable, both for initiatives in the North Caucasus and more generally. They are:

1. PTH initiatives can take place on the inter-community and the intra-community level. They can be useful both across and within ethnically divided communities.
2. PTH initiatives should include PTH capacity-building components, to increase understanding of PTH principles and to develop competence to engage in PTH activities.⁹ Where appropriate, inter-communal or trans-border capacity building or training, in PTH and/or other areas of health-related assistance, can be significant aspects of PTH programs.
3. PTH initiatives should seek to support and empower the existing local health professionals. Programs should provide ample opportunity for exchange of experience among local practitioners, in addition to opportunities for training from outside experts.
4. PTH initiatives should support and empower local NGOs, in addition to supporting and empowering local health professionals.
5. PTH initiatives should seek to promote opportunities for inter-agency dialogue, coordination and cooperation, especially among agencies that do not ordinarily cooperate with each other, or that have no formal channels of communication.

⁹ A variety of PTH training materials are being developed, many of which are based on PTH-related fieldwork experiences. For example, a [Health as a Bridge for Peace Briefing Manual](#) was developed for this consultation and was distributed to all participants. This manual is available from WHO/EURO or IRSS upon request.

6. PTH initiatives should contain a module for the training of PTH trainers and facilitators, in order to promote and propagate PTH concepts and methods.
7. In addition to delivering health care, PTH initiatives should seek to promote the development of healthy, democratic, civil society. One way of doing this is through the development of voluntary action programs, whereby volunteers on the grass-roots level take part in the local PTH activity. Another way is for the PTH initiative to integrate into its program plan a component that improves the social status of women.
8. PTH initiatives should seek to promote the development of a culture of peace. This is especially important in conflict-ravaged areas where children have had minimal exposure to peaceful society and maximum exposure to societies at war. PTH initiatives should therefore seek to promote a culture of peace among children. Through work with children, it is possible to reach other generations, e.g., parents and grandparents, who may be otherwise unreachable.
9. PTH initiatives should strive to develop PTH resources, and then share these resources through their region, and eventually with other PTH initiatives internationally. Such resources could include a PTH library, a PTH Resource Centre for NGOs, or an Information Service.
10. PTH initiatives should include a public awareness educational component, which would seek to educate the public about the programs and goals of PTH. Such an educational campaign could include work with the print and radio/television media, and a range of other advertising and outreach activities, such as PTH stickers on relief packages, and prizes for local "PTH heroes".
11. PTH initiatives should strive to integrate PTH principles into existing health care programs on all levels, from the federal to the regional to the local level. This means that existing health care programs would be encouraged and supported to promote inter-ethnic cooperation, including hiring staff from different ethnic groups where possible.
12. PTH initiatives should seek pro-active ways to educate donors about PTH. In this way donors will understand how their funding practices can either increase or decrease existing conflict. In addition, it is important to build support for the PTH approach and PTH initiatives.

Finally, participants concluded that the implementation of any grass-roots-targeted program must include the following steps:¹⁰

1. avoid regional inequity;
2. maintain flexibility;
3. maintain continuous monitoring of the situation;
4. ensure that plans are validated and owned by the local players; and
5. ensure that programs have an "engine" and resources.

VII. PTH INTER-AGENCY TASK FORCE FOR THE NORTH CAUCASUS

Participants in the consultation agreed that it was desirable to set up an informal, interim, PTH Inter-agency Task Force for the North Caucasus. This Task Force would work to integrate PTH principles into existing and future health-related humanitarian assistance in the region. It was pointed out that WHO is already coordinating health-related activities among the agencies. WHO coordinates international humanitarian health assistance in the North Caucasus through the following mechanisms:

1. policy meetings at the WHO Moscow office every two weeks;
2. field coordination meetings at the Ministry of Health in Ingushetia, Nazran, every two weeks; and
3. information sharing through an electronic information service, a monthly newsletter in English and Russian and a Web-site. (See Appendix D for an example of WHO information dissemination in this area, the WHO "North Caucasus Emergency Health Update, No.14".)

Coordination, although important, is not the same thing as a PTH program. Effective coordination provides a foundation upon which a PTH program can be built. From this foundation it will be possible to analyse existing programs and to integrate PTH activities into them. A PTH program in the region needs to proceed on many levels with many actors. Every agency now working in the region has its own field of activities and its own contact people on the ground. Coordination on this level would be of enormous assistance. WHO could promote the facilitation of a PTH strategy in the region through an inter-agency process. The Medical Alliance for Peace through Health in the North Caucasus can be a coordinating body that helps identify the needs and the opportunities in the field. They are also a source of medical professionals who can help promote PTH activities on the ground. They can work intimately with the Task Force to target appropriate activities for the region. It was suggested that the Task Force have a small Action Committee to serve as a coordinating body for its actions.

The Task Force would have three primary functions:

¹⁰ These "steps" were based on a presentation to the consultation group by David Nyheim of FEWER.

1. Promote PTH concepts and principles

Promotion of PTH could be done through such vehicles as Web sites, professional journals, professional meetings, promotional notices, etc. The WHO Web site for the North Caucasus was volunteered as the first promotional Web site. PTH explanatory literature could be distributed among different agencies. The PTH concept could be promoted through a recognition and awards program. A "PTH Seal of Quality Approval" could be awarded to humanitarian programs that utilize a PTH approach. This seal of approval could be in the form of a sticker that is affixed to aid packages or other visible assistance products. Such a sticker could be a symbol that gives added weight to the specific program while increasing knowledge and understanding of the PTH approach.

It was noted that there is an Association of North Caucasus Physicians which has a monthly newsletter and quarterly meetings sponsored by the Minister of Health in Stavropol. The Task Force should publicize the PTH approach and its goals through this medium. It was pointed out that this organization may not be optimal for reaching Chechen physicians, and that other organizations will need to be researched and approached in addition.

2. Create a PTH database of relevant activities in particular regions

A PTH database could be included in the WHO Web site mentioned above. The database could include case studies of PTH activities and programs.

Preparation of a database will require the gathering of information about institutional resources and needs within the region. A high priority is to develop a list of medical institutions and agencies in the region, and to spread information about PTH to these organizations. A questionnaire will be developed to obtain relevant information from the region, including descriptions of activities, interests and needs. The database will provide important information for the promotional work described above.

3. Promote the adoption of a PTH approach where appropriate

Once the database is under way, there will be a better understanding about which programs in the region can helpfully integrate a PTH approach. At the close of the consultation it was apparent that tuberculosis diagnosis, prevention and control in the North Caucasus could present one PTH opportunity. There was discussion about the possibility of organizing an inter-regional conference and/or program on tuberculosis control and prevention utilizing PTH principles. This will need further exploration.

PEACE THROUGH HEALTH IN THE NORTH CAUCASUS
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Moscow, 4-5 April 2000

APPENDIX A

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE



ORGANISATION MONDIALE DE LA SANTE
BUREAU REGIONAL DE L'EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

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LIST OF PARTICIPANTS

Mr Nabi Abdullayev Freelance Journalist Newspaper "Novoye Delo" Dagestan 436, korpus 3, 92 Kashirskoe shosse, Moscow Russian Federation	Phone Fax e-mail	+7 (095) 392 56 40 nabdullaev@datacom.ru , seidah@mtu.net .
Ms Ljuba Archakova Agency for Rehabilitation and Development Chechnya/Ingushetia Karaboulak camp Russian Federation	Phone Fax e-mail	+7 (873) 4444 685
Ms Marina Baisangurova CPCD 3 Pyatnitskaya str., str.3, app.29 Moscow Russian Federation	Phone Fax e-mail	+7 (095) 953 25 82 +7 (095) 953 25 82 peacecentre@glasnet.ru
Ms. Jairana Bisultanova TB Dispensery Gudermes	Phone Fax e-mail	
Dr Moussa Dalsayev President Association of Psychiatrists of Chechen Republic Pravoberezhnoe, Mirnaya 14 Chechnya Russian Federation	Phone Fax e-mail	+7 (873) 382 322 010 +7 (873) 382 322 011 (via OSCE in Chechnya) moussdal@ahoo.com

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Ms.Raisa Djanieva Karaboulak Clinical Diagnostic Laboratory 1 Rabochaya str., Karaboulak Ingushetia	Phone Fax e-m	+7 (873) 4 44 49 93
Mr Sergei Mikhailovich Furgal Deputy Head Department of International Cooperation Ministry of Health of the Russian Federation 3 Rakhmanovsky per., 101431 Moscow Russian Federation	Phone Fax e-mail	+ 7 (095) 927 26 12, 790 18 51 (mobile) minzdrav@cnt.ru
Dr Paula Gutlove Institute for Resource and Security Studies 27 Ellsworth Avenue, Cambridge Massachusetts 02139 United States	Phone Fax e-mail	+1 617 491 5177 +1 617 491 69 04 irss@igc.org
Dr Nana Gvetadze TB Programme Manager World Health Organization Office of the SRDG 28 Ostozhenka Street, 3rd floor 119034 Moscow Russian Federation	Phone Fax e-mail	8 (501) 414 08 25 or +7 095 787 21 16/17 7 (095) 787 21 19 n.gvetadze@who.org.ru
Mr Boris V. Ionov Russian Red Cross Moscow Russian Federation	Phone Fax e-mail	+7 (095) 126 75 71 +7 (095) 230 28 67 or 310 70 48
Mr Anton Ivanov Forum on Early Warning and Early Response (FEWER) 32 Leninsky prospect, Moscow Russian Federation	Phone Fax e-mail	+7 (095) 938 59 38 +7 (095) 938 06 00 fewer@iea.ras.ru anton@orc.ru
Dr Igor Kazanets Short-term Consultant WHO 217-A Lenina str. 355 017 Stavropol Russian Federation	Phone Fax e-mail	8 (501) 414 08 25 (Moscow) (865) 235 99 64 (Stavropol) 7 (095) 787 21 19 (Moscow) (865) 227 11 25 (Stavropol) i.kazanets@who.org.ru olsenb@unhcr.ch
Mr Gennady Kipor All-Russian Centre for Disaster Medicine “Zashita” 5 Schukinskaya str., Moscow Russian Federation	Phone Fax e-mail	+7 (095) 190 59 63, 190 48 58 +7 (095) 190 54 61 rcdm.org@g23.relkom.ru
Dr Viacheslav Matveyev Short-term Professional	Phone Fax	(865) 2 35 99 64 (865) 2 27 11 25

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WHO 217-A Lenina str. 355 017 Stavropol Russian Federation	e-mail	olsenb@unhcr.ch
Mr David Nyheim Coordinator Forum on Early Warning and Early Response (FEWER) 1 Glyn Street London SE11 5HT United Kingdom	Phone Fax e-mail	+44 171 793 8383 +44 171 793 7975 secretariat@fewer.org
Ms. Margarita Plotnikova International Federation of Red Cross and Red Crescent Societies 5 Chermushkinsky, Moscow	Phone Fax e-mail	+7 (095) 126 77 51 moscow12@ifrc.org
Ms Marina Souslova Russian Red Cross Moscow Russian Federation	Phone Fax e-mail	+7 (095) 126 74 00 +7 (095) 310 70 49
Mr. Kasbar Tashdjan International Committee of Red Cross Moscow Russia	Phone Fax e-mail	+7 (095) 926 54 26 +7 (095) 564 84 31 health.mos@icrc.org
Mr. Jan Theunissen World Health Organization Regional Office for Europe Scherfigsvej 8 2100 Copenhagen Denmark	Phone Fax e-mail	+45 39 17 17 17 +45 39 17 18 56
Dr Stéphane Vandam World Health Organization Regional Office for Europe Scherfigsvej 8 2100 Copenhagen Denmark	Phone Fax e-mail	+45 39 17 12 38 +45 39 17 18 56 sva@who.dk

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Dr Vladimir Verbitski
World Health Organization
Regional Office for Europe
Scherfigsvej 8
2100 Copenhagen
Denmark

Phone +45 39 17 13 39
Fax +45 39 17 18 56
e-mail vve@who.dk

Dr Liubov Yerofeeva
UNFPA
28 Ostozhenka str.
Moscow
Russian Federation

Phone +7 (095) 787 21 13
Fax +7 (095) 787 21 37
e-mail lyubov.yerofeyeva@unfpa.org.ru

Mr Nicolai M. Zoudilin
Head
RRC Headquarters of Humanitarian
Assistance to North Caucasus
Russian Red Cross
Moscow
Russian Federation

Phone +7 (095) 126 15 02
Fax +7 (095) 230 28 67 or 310 70 48
e-mail

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Appendix B

“Peace Through Health” Inter-Agency Consultation
Moscow, 4-5 April 2000
Preliminary Agenda

Day 1: April 4, 2000 (10:00 - 17:30)

Session I: Welcome and overview of Peace Through Health (PTH)
10:00-12:00 (break 11:00--11:30)

1. Welcome
 - a. Welcome: Vladimir Verbitski, Mikko Vienonen and Paula Gutlove
 - b. Overview of the meeting
 - c. Participant introductions
 2. Peace Through Health
 - a. PTH: principles and strategies: Paula Gutlove
 - b. PTH programs: history and field experiences
 1. WHO PTH in the Balkans:
 - * Stephane Vandam, Desk Officer, WHO/EURO
 - * Medical Network for Social Reconstruction in former Yugoslavia: Paula Gutlove
 2. WHO PTH in the Caucasus: Vladimir Verbitski et al
- Break 11:00-11:30
3. North Caucasus in context (60 minutes)
 - a. Social Context: David Nyheim (20 minutes)
 - b. Reports from the field:

Discussion

Lunch 12:30-14:00

Session II. Information exchange and the PTH link
14:00-17:30 (break 15:30-16:00)

4. Information exchange regarding health-related humanitarian activities in the North Caucasus
 - a. Presentations by relevant agencies: existing and planned health-related humanitarian assistance activities
 - b. Overview of related activities
 - c. Discussion

Break 15:30-16:00

5. Linking the PTH approach to existing and planned activities
 - a. Mapping and analysis of existing and planned activities
 - b. Assess the potential for linking the PTH approach to health-related humanitarian assistance activities
 - c. Assess the potential for linking the PTH approach to specific interventions

Day 2: April 5, 2000 (9:00 - 17:30)

Session III : Development of an inter-agency PTH action plan
9:00-12:00 (break 10:15--10:45)

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6. Inter-agency PTH action plan
 - a. drafting of an action plan based on mapping, analysis and small group reports from session II
 - b. developing an integrated implementation strategy

Lunch 12:00-1:30

Session IV : Form an inter-agency task force on PTH
1:30-5:30 (break 3:15-3:45)

7. Discussion of an inter-agency task force for PTH in the North Caucasus
8. Planning the next meeting of the inter- agency task force
9. Conclusions

Day 3: April 6, 2000 (10:00 - 16:00)

Optional individual meetings to be scheduled among relevant agencies and individuals, to discuss implementation details of specific PTH action plans.

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Peace Through Health, Inter-Agency Consultation
Text of Power Point presentation by Stephane Vandam
To the Interagency Consultation, Moscow, 4-5 April

Mandate of WHO

General principles from the experience of WHO in Bosnia and Herzegovina

Personal experience

WHO's Mandate

Public health

Peace Through Health

Aims: to integrate health development and conflict resolution

Opportunities for peace

A process as much as outcomes

Create healthy , peaceful environments

Peace-building Approaches

Political

Structural

Social

Eastern Slavonia (UNTAES)

Joint implementation committees

Public Health Interventions

Sub-national immunization days against polio

Mental health multi-ethnic group

CBR multi-ethnic group

Health information system commission

The Federal Republic of Yugoslavia

Sub-national immunizations days in the province of Kosovo

Disease surveillance system: multi-ethnic capacity-building activities

Mental health workshops

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Appendix D

North Caucasus Emergency Health Update



No.14, 16 May 2000

**Health assistance to the population affected by the emergency.
Compiled by WHO.**

Disclaimer: This is not an official WHO publication. Information is collected from various sources, mostly relief agencies' reports, and might not be fully comprehensive. Comments and additions are welcome. Please contact WHO Office in Moscow by Email: par@who.org.ru

Chechnya

Demography

According to DRC data there are now about 650,000 people inside Chechnya. (April 27). RF Government Envoy in Chechnya reports that there are 137,112 pensioners and 11,516 disabled people there.

It is very difficult to determine with any precision how many people have moved to Chechnya and how many remain in Ingushetia, as many are constantly moving back and forth. An estimated 80,000 people are now in Grozny, with up to 1,000 more arriving daily. (PINF)

Basic infrastructure

Lack/intermittent supply of gas, water and electricity remain a grave problem. In order to cover Grozny's needs of electricity EMERCOM has installed 14 generators.

Water and sanitation

35 EMERCOM water trucks distribute drinking water throughout the city of Grozny. EMERCOM has also established shower units there. Still, only 10-12% of population needs as regards to water are covered.

Ecological situation

The air in the centre of Grozny is highly contaminated with dust, oil is burning 24 hours a day at several locations, ground around the oil company is polluted with oil. (PINF)

Health situation

Morbidity

All sources rank ARI first in infectious diseases in IDP population. (Zaschita, MSF-H)

As far as the second and the third places opinions differ. The second most common disease is considered to be either

gastro-intestinal infections or pediculosis, the third place is given to cardiovascular diseases/acute intestinal infections respectively. (MSF-H, Zaschita)

As of May 10 epidemiological situation in the village of Lermontovo-Yurt/Achkhoi Martan region (Chechen Republic) where an outbreak of typhoid was registered at the end March, is stable. According to the latest information 42 people were registered sick, 17 of them were hospitalised (including 4 children). (Zaschita)

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Mortality

Data from accessible health facilities visited by MSF-H indicate that cardio-vascular diseases are the main cause of adult mortality, oncological diseases/tumours rank second, gunshot wounds and mine injuries ranks third; as regards to child mortality ARI and diarrhoeal diseases were reported to be the main cause of death, gunshot wounds and mine injuries being in the top 3.

Vaccination

PINF reports that the first round of vaccinations has been done in Grozny and the second is planned for the second half of May).

Nutrition

In Grozny PINF staff reports visible lack of food, with many people (probably those who remained in the city during the war) looking exhausted and undernourished.

In Grozny food distribution points distribute milk powder formula to children (1 500 g box every 2 days). (PINF)

The major part of assessed child health care facilities reported anaemia to be a big problem. It is caused by iron deficiency and indicates the insufficiency of meat in children's food. (MFS-H).

Health services

Drugs and supplies

Official system of regular distribution of medical supplies was already limited before the conflict, now it seems to have collapsed totally. 75% of facilities visited by MSF-H reported that no drugs or materials have been supplied lately. Stocks are minimal or non-existent. While central district hospitals are most likely to receive some limited support from health authorities, supplies to Divisional hospitals are less likely, and virtually none of the PHC facilities or medical dispensaries visited have a stock of essential drugs/materials. Northern districts are most likely to have regular supply from authorities.

If available, drugs are given free of charge to those who can not afford. However due to lack of supply/stock vast majority of patients have to buy drugs and materials in private pharmacies (even in emergency cases), where prices are reported to be high and choice of drugs and materials limited.

Supply of vaccines seems to be the rare exception. 80% of all health facilities visited by MSF-H reported to have vaccination activities, of which 85% had most EPI vaccines available, polio and DTP vaccines were reported to be sufficient in stock, some facilities reported shortages of Measles, Tetanus and BCG vaccines.

All health-facilities with surgical services report lack of anesthetics, oxygen and surgical materials.(MSF-H)

Equipment

Availability of cold-chain equipment and storage facilities for these vaccines is worrying. Of all facilities with vaccination activities only 38% had a functioning refrigerator, some facilities had fridges available but out of order, leaving the majority without proper storage facilities. With regard to problems with power supply and the fact that cold chain is regularly broken, the efficacy of the vaccines administered seems questionable.

61% of the hospitals visited had laboratory equipment, another 18% had equipment available but not functioning, and all facilities reported a chronic lack of lab reagents.

Only 32% of the hospitals visited had functioning X ray equipment available, another 21 % had equipment available but not functioning. Main problems mentioned here was the chronic lack of X ray film and electricity cuts.

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A large proportion of functioning hospitals needs equipment for sterilizing instruments and materials (avtoklavs).

Another problem is lack of small generators and means of transportation and fuel. (PHO)

Surveillance

Systematic collection of health data seems to be non-existent. Although in most facilities some sort of registration is being conducted, in most facilities monthly reports/ statistics on morbidity and mortality are not being compiled nor collected systematically by health authorities.

Registration on war related injuries and trauma is problematic.

Access

Access to functioning healthcare facilities is limited for population living outside the facility neighbourhood. Especially during evenings and nights access is a problem due to curfews and checkpoints.

Water and sanitation

Water and sanitation situation in health-facilities is poor. Although 88% of the facilities visited by MSF-H had some sort of water supply, 46% of hospitals rely on trucked water, 29% rely on wells and in 14% of hospitals water-supply depends on availability of electricity. Sewage systems and toilets are not functioning, neither do light and heating. Number of toilets and washing areas is insufficient. At the medical dispensary level the majority of facilities (57%) relies on well or spring water, only 18% is provided with water through water trucking. The quality of trucked water and alternative water sources is bad, due to the grave environmental situation. Combined with the lack of waste disposal and garbage collection, the situation is considered to be precarious.

Electricity

Only 53% of hospitals had electricity available on the day of the visit, back-up generators are rare. generator. At Polyclinic/ Medical dispensary level only 32% had electricity on the day of visit, with several having a generator for back-up. (MSF-H)

Human resources

The number of physicians (including specialists) in Chechnya is reported to be 876, nurses 2309. With the estimate of current population in Chechnya being 650,000 this translates to 1 doctor per 742 inhabitants, 1 nurse for 281 inhabitants which is above the accepted standard set by the WHO. (MSF-H)

Health assistance

Assistance by national health structures

- On 11 of May All-Russian Centre for Disaster Medicine, “Zaschita”, reported that out of the existing 62 hospitals/ ambulatory posts and 88 feldsher-obstetric posts in the city of Grozny and in Naursky, Nadterechny, Gudermessky, Groznensko-Selsky, Schelkovsky, Achkhoi-Martanovsky, Urus-Martanovsky, Shalinsky, Nozhai-Yurtovsky and Shatoisky districts 23 hospitals, 22 ambulatory posts and 58 feldsher-obstetric posts were in operation. Medical facilities continue to be understaffed: there are about 65% doctors and 50-80% nurses.
- In early May a “Zaschita” field hospital in Grozny completed its work and was removed.
- In March-April Zaschita held several rounds of professional training for 195 doctors and nurses in Gudermes and Naurskaya. Medical college in Gudermes received updated training modules.

International health assistance

- ICRC assists hospitals in Grozny, Achkhoi-Martan, Urus-Martan and Gudermes.

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- MDM is running a surgical program comprised of delivery of surgical facilities to hospitals in Chechnya.
- MSF-H provides emergency support to key health facilities throughout the Chechen territory by providing essential drugs and materials as well as by emergency repairs. Emergency distributions at 29 hospitals and 28 ambulatory facilities have been organized since 18 March. MSF plans to continue support of key facilities.
- UNICEF will shortly provide 30 cold boxes and 60 vaccine carriers to support vaccination campaign.
- PHO has recently delivered 4 trucks of medical and other aid for hospitals, baby food and sanitary kits.

Land mines

Land mines are a grave problem. Although it is difficult to obtain official statistics, local doctors report that 3-5 people are hurt daily by land-mine related explosions in Grozny. (PHO)

An official from the Temporary Administration of Chechnya reported that there are 5000 victims of land mines registered in Chechnya at present. 50-70% are low extremities amputees. Although, realistically, this figure may well be doubled.

In Grozny the existing warning signs "Mines" do not seem to be put where the real threat is. They are rather a security measure to warn people not to enter certain buildings and spots. (PHO)

There is no on-going mine awareness campaign at present. (OCHA)

UNICEF is planning to approach DRC who has experience in developing a mine-awareness campaign in Ingushetia OCHA/Moscow will also be approached given its knowledge of similar activities in Georgia.

WHO provides prostheses to landmine victims through its workshop based in Vladikavkaz. If situation allows similar workshop might be set up in Ingushetia and/or in Chechnya.

Areas around Chechnya (including Ingushetia)

Demography

As of May 12 there was a total of 179,624 Chechnya IDPs in Ingushetia with 130,000 of them living with host families. (Head of EMERCOM/Ingushetia).

According to the Head of the Ingush Migration Service, 37,000 IDPs from Chechnya living in Ingushetia officially confirmed their intention to reside in Ingushetia.

Health Situation

Communicable diseases:

As of 25 April, 00 5 cases of Crimean haemorrhagic fever have been registered in 3 regions of Stavropol krai.

Non-communicable diseases

According to the representative of the RI Sanitary Inspection Service a large number of food poisonings has been registered in IDP camp in Aki-Yurt in early May.

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Vaccination

As of May 11, MOH/I has performed immunization of 29 826 IDPs. (MoH/I)

Tuberculosis

- As of 11 May, screening efforts initiated by the MoH/I resulted in 19,244 IDPs X-rayed, the number of TB cases diagnosed being 223. (MoH/I)
- On 17-21 April WHO conducted the training course for doctors, laboratory assistants and health care personnel from North Ossetia in Vladikavkaz, aimed at improvement of TB diagnosis by microbiological methods.

Another course

for laboratory workers from Dagestan is being conducted on May 15-19 in Moscow.

Reproductive health

As of 11 May, the number of new-borns in the IDP population was 2,677, of them 49 were stillborn and 28 died later (MoH/I).

WHO field monitors in Ingushetia have completed a round of gathering information on the quality of maternity homes services and out-patient services for newborns and infants for local and displaced population. The results of the survey are now being evaluated. (WHO)

UNFPA and WHO will undertake a joint Reproductive Health Assessment mission to Ingushetia from 17-22

May. Equipment and supplies for safe delivery, maternal care, and STI/HIV/AIDS prevention will then be

procured and distributed to public health structures and mobile clinics operated by international NGO's. In addition, MOH staff will receive refresher training on emergency obstetric care and advanced

reproductive health technologies. Educational materials on reproductive health and rights will be distributed among IDP's in Ingushetia. (UNFPA)

Health services

Hospitals

2 remaining modules of Zashita field hospital in Slepsovskaya are run by medical teams of the Centre of Disaster Medicine of the Republic of Ingushetia.

Laboratory facilities

IOM is engaged in upgrading of 2 TB laboratories in North Ossetia and Ingushetia.

Equipment

Ingushetia: 11 oxygen concentrators are needed to cover the needs of Ingushetian medical facilities (WHO).

Mobile clinics

IMC mobile medical clinics for displaced persons work in 28 spontaneous settlements within Ingushetia. They aim at provision of basic curative services to population as well as immunization of children under 15 years of age and provision of pre-natal control and neo-natal counselling to pregnant women.

PINF operates a mobile clinic providing primary health care services for approximately 4,000 IDPs in 24 spontaneous settlements. The NGO also supports IDPs with medical evacuations and hospital consultations.

International Health Assistance and supplies

MSF-H renders emergency support to health facilities in areas with high concentrations of displaced throughout Ingushetia. Assistance includes 1) Provision of essential drugs and materials

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according to identified needs. 2) Surveillance of health developments. 3) Systematic monitoring of access to medical services, provision of basic health care and availability of free essential drugs to target population.

Distributions since the middle of March supplied basic medical supplies to: all central district hospitals and polyclinics;

Nazran city hospital and polyclinic; 22 dispensaries. MSF plans to continue support to Facilities with essential drugs and materials.

ICRC provides regular medical assistance to 5 hospital in Ingushetia. Since October 99 ICRC assisted 1,500 wounded with drugs and surgical materials.

In Dagestan IRCR rendered medical assistance in the form of medicines and medical materials to 365 wounded, as well as it assisted 50 patients from Khasaviurt Central Hospital.

In Kabardino-Balkaria and North Ossetia ICRC assisted military hospitals in Nalchik, Mozdok, Vladikavkaz, Piatigorsk and Kislovodsk with emergency medical supplies for 1,125 wounded.

Water and sanitation

ICRC runs 8 water cisterns which deliver water to 61 points in IDP camps and spontaneous settlements. Along with distribution of water to IDP population, ICRC regularly fills in 21 water tanks. More than 31,000 IDPs receive water daily.

223 cubic meters are delivered daily. On the whole, 21,000 cubic meters of water have been provided to Ingushetia since October 99. Two shower units were installed in IDP camps.

MSF-B has recently installed 14 latrines and put 19 showers into operation in IDP settlements in Malgobeck area.

Although it seems that at present IDP needs in water are more or less covered, it is clear that with the coming of summer they will significantly increase and the existing facilities will face serious difficulties. (IRC)

Land Mines

DRC is presently developing a landmine awareness campaign around 65 distribution points in Ingushetia.

Assistance to disabled IDPs

In April Organization "Handicapped International" has provided MDM with a gift of 100 wheelchairs and 200 pairs of crutches for disabled population of North Caucasus. IMC has also received a wheelchair donation in May.

WHO has conducted a survey of disabled IDPs in Ingushetia, and is ready to share its data on the needs of disabled IDP invalids with all organizations concerned. WHO prosthesis workshop in Vladikavkaz continues to render assistance to disabled IDPs.

COORDINATION

WHO coordinates the international humanitarian health assistance in the North Caucasus through the following mechanisms:

- 1) Policy meetings at the WHO Moscow office every two weeks.
- 2) Field coordination meetings at the Ministry of Health in Ingushetia, Nazran, every two weeks.
- 3) Information sharing through an electronic information service, a monthly newsletter in English and in Russian and this web-site.

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List of abbreviations:

DRC - Danish Refugee Council
EMERCOM – Ministry of Emergency Situations
ICRC - International Committee of the Red Cross
IMC - International Medical Corps
IOM – International Organization for Migration
IRC – International Rescue Committee
MDM - Médecins du Monde
MOH/I – Ministry of Health of Ingushetia
MSF-B - Médecins sans Frontières-Belgium
MSF-H - Médecins sans Frontières-Holland
PINF – People in Need Foundation
PHO – Polish Humanitarian Organization
UNICEF - United Nations Children’s Fund
UNPFA – United Nations’ Population Fund
WHO – World Health Organization
Zaschita – All-Russian Centre for Disaster Medicine
“Zaschit