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Final Report

PRESENTED BY THE

HARVARD HUMANITARIAN INITIATIVE

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INTRODUCTION

The humanitarian response to disasters and war-related crises has been gradually evolving toward increasingly systematized interventions. Aid organizations, technical experts, United Nations agencies and donors alike have recognized the need to advance the field through professional development, minimum standards of quality, and epidemiological assessments to drive programming and measure impact. The movement toward professionalization, however, has been limited to large organizations—and mechanisms for collective action across organizations remain elusive.

At the request of several international relief organizations, the Harvard Humanitarian Initiative has since 2006 provided a forum for dialogue on operational issues. The mission of the Humanitarian Action Summit meetings and working groups is to:

- Identify new and unresolved challenges impairing the effectiveness of the humanitarian assistance community
- Identify field or policy-level issues and promote positive change through collaborative discussions, analysis, debate and research
- Provide specific actions and guidelines that will advance policy and/or best practices

From March 4-6th 2011, the Harvard Humanitarian Initiative hosted its fourth summit and convened over 200 prominent leaders from across the humanitarian community to discuss the state of crisis response and map how to build more effective humanitarian action. Bringing together decision-makers from academia, international NGOs, the United Nations, and federal agencies, the 2011 Humanitarian Action Summit allowed participants to consider and evaluate the most advanced evidence-based practices in humanitarian aid. Throughout the weekend, these leaders in humanitarian response shared their expertise and built partnerships to address the greatest concerns facing the global humanitarian community.

The Humanitarian Action Summits have the unique capacity to address problems experienced by the humanitarian community and develop solutions. In great part this is due to the fact that the Summit primarily places the responsibility for the work with humanitarian decision-makers and those working in the field. Since 2006, the Summit has produced major standards and research initiatives that have advanced both the knowledge-base as well as the quality care performance of the humanitarian profession. The 2011 Summit addressed the following key issues and challenges facing the humanitarian community:

- Rapid urbanization represents the most significant demographic change of the twenty-first century. This migration is further stressing already overburdened, underdeveloped infrastructure and leading to public health and security emergencies. Humanitarian emergency layered upon this background of un-sustainability and vulnerability represents an acute-on-chronic crisis. Most of the tools and standards broadly employed by humanitarian organizations were developed for a rural environment and are unsuitable for application in this increasingly urban context.

- Life saving emergency surgery by Foreign Medical Teams especially during the 2010 Haitian earthquake revealed serious concerns about the clinical competence and practices of some teams and their providers and called for greater accountability, coordination, and standards of care.

- Limb amputations are frequently performed as a result of trauma inflicted during conflict or disasters, and coordinating care of these patients in austere settings is complex. Haiti's earthquake left approximately 1500 amputation survivors relying on a healthcare system whose baseline, pre-earthquake surgical, anesthesia, rehabilitation and prosthetic services were already impoverished. The disparities in quality of care received by Haitians with amputations highlights the necessity of multidisciplinary field guidelines to address the comprehensive medical needs of persons undergoing amputation in humanitarian emergency settings.

- Mental Health issues dominate long-term mortality and morbidity of victims from large-scale natural disasters and war and conflict. To date, the humanitarian community has focused primarily on short-term emergency treatment and neglected the long-term consequences.

- The rapid rise in the use of information and communication technologies brings potential promise to the ways in which humanitarian assistance can become engaged in worldwide crises, but also presents new challenges. Information bottlenecks, delays, and inaccuracies often leave a perilous vacuum in which humanitarian responders arrive and direct resources haphazardly and real population needs remain unmet.

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The participants and planning committee agreed to take responsibility upon themselves for making progress toward the future steps outlined here. The immediate publication of the findings of the Summit into peer reviewed journals has already accelerated the acceptance of new standards of care vitally needed for the humanitarian community. We look forward to keeping stakeholders up to date on the progress toward these action points and our collective goal of promoting excellence and professionalism in the humanitarian community.

We hope the Humanitarian Action Summit will continue to serve as a resource for strategies, technical expertise, and coordination in the prevention, mitigation, and response to disasters.

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HARVARD HUMANITARIAN INITIATIVE

The Harvard Humanitarian Initiative (HHI) is a university-wide center involving multiple entities within the Harvard community that provide expertise in public health, medicine, social science, management, and other disciplines to promote evidence-based approaches to humanitarian assistance.

The mission of the Initiative is to relieve human suffering in war and disaster by advancing the science and practice of humanitarian response worldwide. Harvard Humanitarian Initiative fosters interdisciplinary collaboration in order to:

- Improve the effectiveness of humanitarian strategies for relief protection and prevention;
- Instill human rights principles and practices in these strategies;
- Educate and train the next generation of humanitarian leaders.

WORKING GROUPS

Urbanization and Humanitarian Emergencies: Challenges and advantages to program design and preparation in complex urban landscapes

Surgical Issues in the Humanitarian Space: Best practices for surgery in disaster and conflict & Multidisciplinary guidelines for amputations following disasters and during conflict

Mental Health and Psychosocial Support in Crisis and Conflict: Transitioning mental health and psychosocial programs from short term relief to community-based programs for development

Humanitarian Technologies, Crisis Mapping, and Challenges in Information Management

Field Level Coordination among Civilian and Military Humanitarian Actors: Strategies for improving dialogue and performance

NGO Security and Staff Protection: Information sharing and coordination

PROPOSED GUIDELINES FOR HUMANITARIAN STANDARDS AND OPERATIONS IN URBAN SETTINGS

Background

Rapid urbanization represents the most significant demographic change of the twenty-first century. The year 2008 marked the first time in human history when over half of the world population lived in urban settings. The process of urbanization, fueled by broad economic and social forces, has accelerated particularly in countries of the Global South, and shows no signs of slowing. By the year 2050, it is predicted that 70% of the world population will live in urban settings.

Of particular concern to public health are the urban poor that face multiple health threats, live in a state of chronic crisis, and reside in extremely dense, poorly built slums without basic infrastructure or services and high levels of insecurity. Of the growing global urban population, slum dwellers make up an estimated one-third, and over 60% in some rapidly growing cities, totaling over one billion worldwide.

Humanitarian organizations, international agencies, and governments seeking to serve the populations affected by wars and disasters find themselves increasingly in an urban context as these crises now drive populations to urban centers rather than refugee camps and affect urban populations more frequently. Agencies face a new set of challenges in these complex urban environments and are only just learning to adapt and plan for the rapidly urbanizing world. The Urbanization and Humanitarian Access Working Group (UHAWG) is a collaboration among representatives from humanitarian aid organizations, international agencies such as the World Health Organization and United Nations, academia, and the Sphere Project, formed to explore the issues presented by urban humanitarian emergencies and to generate potential solutions.

Starting with Sphere

In the months leading up to the Humanitarian Action Summit of 2011, the Working Group started their discussion around the first of two major objectives: determining how the Sphere Standards may apply or need to be modified for these new and complex urban landscapes. The Sphere Standards are a set of minimum standards and guidelines based on human rights and developed to guide the aid and assistance community during

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humanitarian crises. Many of these standards, however, are not met by urban slums at baseline.

The working group went through each of the 2004 Sphere Standards and commented on the relevance to and possible adaptation for urban settings. Working group members also commented on how to approach adapting the Sphere Standards to urban settings, including what new data is needed and what contributing factors need to be considered. The majority of the standards were thought to be relevant in urban settings and many required no modification, but several required adaptation to be relevant to the urban environment. Discussion around possible adaptations opened up recurrent themes that needed to be addressed.

Many standards are not met at baseline

One of the most apparent challenges for humanitarians working in urban settings is that conditions in most slums and informal settlements during non-emergency times are well below the minimum standards set by Sphere.

Potential variation in quantifiable standards

The UHAWG consistently identified the need for new data to guide recommendations on adaptation in order to answer the above questions. The quantitative standards in Sphere, and most studies that have looked at health indicators' relationships to mortality, have been based on data from refugee camps. These studies must also account for differences in standard health risk factors as well as geographic location, refugee/internally displaced versus long-term populations, and other factors with potential health impacts, such as abject poverty, that vary widely but cannot be ignored in urban conclaves.

Limitations of space

A fundamental challenge in cities is the severe limitation in space. Slums by their very nature attempt to utilize every available inch of land, including land unsuitable for shelter, while maintaining extreme density. There is generally little available land for establishing new settlements or sanitation facilities, and mandating certain distances between dwellings is not feasible. While Sphere prioritizes migrants settling with host communities and families, this is even more difficult in a dense urban area already at the limits of absorptive capacity.

Potential alternative or additional standards

Some of the Sphere Standards may also be less relevant in urban slums than rural camps, and in some cases new alternatives could be considered. For example, while walking distances to health facilities are probably shorter in urban settings, waiting times may be longer and safety may be a greater

concern. Therefore, the round-trip time may be a more appropriate indicator for ease of access rather than walking time or distance alone.

Additionally, urban environments present specific risks that require additional standards. For example, slum settlements are at high risk of fire and flooding so they may necessitate standards around fire prevention and flood zoning.

Working Group Findings

Added complexity in the urban context

Complexity is a universal characteristic of humanitarian engagement, even in the most remote rural settings. Historical context, political factions, ethnic and cultural diversity, and the dynamic nature of armed conflicts and ongoing disasters all add to the complexity that humanitarian agencies must navigate in virtually all of their work. Another layer of complexity in urban settings comes largely from pre-existing institutions including government, NGOs, military and police, informal authorities and civil society, just to name a few.

Engaging with government

Humanitarian agencies routinely work within the existing local government but officially engage with national-level officials such as the ministry of health. In an urban setting, the local municipal government may be a more valuable partner than the national government. A complicating feature of working in complex urban settings is that slums generally develop outside of a local government's control. Officials may turn a blind eye on their responsibilities to the newly arriving population. Some city mayors preside over populations of 10-20 million, larger than some medium-sized countries. Humanitarian agencies must be familiar with governmental structures and be politically savvy in understanding the attitude of the municipality toward the beneficiary population.

Engaging with civil society and local NGOs

In addition to complex and cumbersome government bureaucracies, humanitarian agencies in urban settings also face a myriad of non-governmental organizations (NGOs) and civil society actors. Especially in acute-on-chronic disasters, partnership must be a guiding principle of humanitarian engagement. Partnerships allow agencies to identify the most vulnerable populations, coordinate their efforts so that major needs are not missed, and generate buy-in for their work. These are also the same organizations that will stay in the cities long-term, and building strong links

from the initial assessment is key to planning sustainable exit strategies and transitions to sustainable livelihood development.

The Haitian experience

The 2010 earthquake that struck Haiti highlighted the realities of the challenges in meeting Sphere standards in urban post-disaster settings. The response in Haiti was extraordinarily fast compared to prior disasters; within 4 months of the earthquake, 1.5 million people had full emergency response services. Yet as they have moved from relief to recovery, people moved into areas that were already substandard, forming slums outside the city in flood plains and on landslide-prone hillsides. When attempting to create better shelter options, humanitarian agencies were faced with the limitations of urban space. Currently, they are utilizing private contractors to build multi-story homes to compensate for the population density and experimenting with financing schemes for renters rather than assuming beneficiaries will be homeowners. NGOs also became involved in providing municipal services like water distribution and sanitation; they now face the challenge of transitioning these services back to municipal control where beneficiaries pay for utilities that were free during the disaster phases.

Overall, humanitarian agencies were unable to meet humanitarian standards in Port-au-Prince. One study of the Parc Jean Marie Vincent IDP camp in Port-au-Prince showed that while minimum standards for healthcare and water access were met, those for food, shelter, sanitation, and security were not. Given that Port-au-Prince is a relatively small city which had a population of only 2.5 million, these issues will only be magnified when a disaster strikes a larger city.

Challenges in the urban setting

The UHAWG also discussed several challenges specific to working in urban slums. These include health burdens that are associated with urban living, land ownership and land-use regulations, and the inability to differentiate displaced from local populations.

Urban health burdens

Extreme population density and poor water, sanitation, and healthcare infrastructure in urban slums greatly increase the risk of disease transmission. Other health burdens have higher prevalence in urban centers including motor vehicle injuries, obesity and related non-communicable diseases, and illness secondary to environmental hazards.

Violence, crime, and banditry by predatory gangs are on the rise where guns and weapons of war are becoming more prevalent in civilian hands. The nature of unregulated and un-policed slums allows the proliferation of the

arms trade, crime, and violent gangs. The most vulnerable groups: women, children and the displaced, bear the brunt of this insecurity.

Land ownership and use

Both the local poor and displaced populations tend to move to wherever they can find cheap unregulated land, and this is where slums tend to form, both after disasters and in non-emergency times. Slums tend to form on land not zoned for housing in flood plains and landslide-prone areas.

Given the illegal nature of many slum settlements, humanitarian actors face the task of working with city leaders to gain both permission and partnership to build facilities in these areas such as latrines, sewage systems, water taps, and housing. This infrastructure development is best done in concert with the pre-existing infrastructure and long-term strategic public health planning. For example, rather than building pit latrines, a sewage system that connects to the rest of the city's sewage is preferable. Also, displaced populations that settle in slums often establish and maintain their tenure on a piece of land through occupancy. Therefore, it may not be advisable to prioritize their return to their prior settlements since even temporary displacement puts them at risk of losing tenure.

A government's view of a population's migration and settlement affects that population's ability to utilize resources, gain employment, and secure land tenure. Countries vary in their recognition of the UN Refugee Convention. When refugees migrate to urban settings, it is unclear what institutions hold primary responsibility for their well-being. In refugee camps, humanitarian NGOs traditionally hold that role under the auspices of UNHCR. In rapidly urbanized conclaves, there is a question of how much responsibility should be put on the local government. The UHAWG believed that city governments must share responsibility with humanitarian agencies from the outset.

Inability to differentiate refugees from locals

A further challenge is the inability to differentiate the internally displaced or refugees from the local indigenous population. The UHAWG thought that the best way to address this dilemma would be to avoid providing services exclusively to refugees. This way they are seen as bringing a benefit to the area rather than using overburdened local resources. In urban settings, humanitarian interventions should be developed with an eye toward reaching the standards for the *entire* population in a sustainable way and integrated into a longer-term urban planning process.

Advantages of urban settings

While the challenges of urban settings can be daunting, there are also a number of advantages and opportunities that come with working in cities. These include pre-existing supply chains, economies of scale, infrastructure and availability of technology, and a monetized economy. As a counter to political challenges, there arise opportunities for advocacy for slum populations. Urban environments also present opportunities to effectively implement urban planning and disaster preparedness to mitigate the effects of future crises.

The urban advantage

As centers of trade and commerce, cities have pre-established markets and supply chains, which can be valuable tools for humanitarian agencies. The high prevalence of cell phones and telecommunications infrastructure can be used in urban settings for data collection, crowd sourcing, mapping unknown slums, information dissemination, and multiple other purposes. Finally, the monetized economies in cities, both formal and informal, allow for a range of interventions and resource provision. Since almost all goods are acquired and available through purchase in cities, using cash transfers, cell phone credits, or vouchers may allow people to access the same goods that aid organizations used to provide in-kind through existing supply chains. This process makes logistics easier for aid organizations and supports the local economy.

Advocacy opportunities

While a large municipal government and other established political actors may create undue complexity, they also present opportunities for humanitarian agencies to advocate for the well-being of displaced populations and the urban poor in general. This can be accomplished in part by promoting appropriate standards for service provision and viable public health infrastructure to municipal governments.

The humanitarian community must approach this in a way that accounts for the interests of the municipal government. Government officials may not immediately see how providing for slum dwellers or migrants is in their best interest. Rather than taking the naming and shaming approach, humanitarians must not only reveal potential problems and risks, but why it is in the government's interest to address them now and not later. Showing the financial advantage of providing basic services and planning for these populations has always been a strong tool for advocacy. A perfect opportunity for this is the immediate post-crisis period. Additionally, humanitarian organizations must target policy-makers at critical non-crisis moments that allow for advocacy, such as when cities host major international events.

This advocacy and education should also extend to the non-governmental actors and the slum occupants themselves. The communities themselves can use data gathered by humanitarian agencies to aid in service provision and development. In doing so, there is an opportunity to change normative frameworks of advocating for human rights for slum populations.

Conclusion and Future Directions

The inaugural meeting of the UHAWG was an active collaboration of humanitarian experts with interests in humanitarian work in urban settings. Initial discussions focused on laying out the context, challenges, and opportunities that humanitarian agencies face and lay the groundwork for future initiatives.

Next steps for the UHAWG

As a part of the humanitarian community, the Harvard Humanitarian Initiative (HHI) and the UHAWG will undertake several tasks to continue their work. This includes:

- Collaborating with groups that are developing standards and policy recommendations for urban settings.
- Developing case studies that evaluate slums in various regions in comparison to Sphere Standards.
- Investigating the impact of density and other aspects of rapid urbanization on health and well-being, as well as interventions aimed at improving conditions.
- Collaborating with agencies that are developing practical technical standards and documents for humanitarians working in urban settings on a variety of activities from water to livelihoods and shelter.
- Convening and soliciting feedback from scholars, policy makers, and organizations in cities around the world that are already adapting to these circumstances with creative solutions.
- Developing tools for the humanitarian community, policy-makers and communities to understand and mitigate the risks of future humanitarian crisis in urban environments.

A BLUEPRINT FOR THE DEVELOPMENT OF PREVENTION AND PREPAREDNESS INDICATORS FOR URBAN HUMANITARIAN CRISES

Background

As rapid urbanization creates complex environments that concentrate the risks and hazards to man-made and natural disasters, it also presents a vital advantage that must be exploited. Urban humanitarian emergencies by their very nature occur within the geo-political sphere of a governing body, the municipal government, and as such they are the responsibility of that body. It is the duty of municipal governments to prevent and prepare for and respond to humanitarian emergencies that may affect their citizens. Preparedness at the city level, therefore, remains an incredibly valuable area for development to mitigate the effects of humanitarian crises. Rapid urbanization now allows a greater proportion of the population to fall under a responsible municipal government and an opportunity to promote and advance urban planning around preparedness.

The Urban Health Equity Assessment and Response Tool (Urban HEART) is a tool for municipal governments to identify, analyze, and track health inequalities. It is accompanied by a collection of best practices to intervene upon for poor performing areas. Developed by the World Health Organization (WHO) Kobe Centre, it has been implemented throughout the world. Currently, it features indicators on both health outcomes and social determinants of health.

The current design of Urban HEART indicators allows cities to measure inequalities in a predetermined set of "standard" indicators that affect or reflect the health of its population. However, it currently does not include indicators on the prevention and preparedness of a city for a humanitarian emergency such as a natural or man-made disaster. Ensuring adequate planning and preparedness is the first step in responding to these inevitable crises.

The *Urbanization and Humanitarian Access Working Group (UHAWG)* aimed to develop preparedness indicators for humanitarian emergencies that could be incorporated into Urban HEART. The working group (WG) believes that this is a valuable tool that should continue to be scaled-up to cities across the globe. This objective allowed the WG to promote urban planning

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for humanitarian emergencies and scale up its adoption by city governments across the globe through a tool and program already developed by the WHO. The discussion focused on key areas, which the group thought should be included in an overall assessment of disaster readiness as modeled after exiting Urban HEART indicators.

Working Group Findings

During the session, several common themes emerged as crucial to the development of new indicators. The WG decided that acknowledging the complexities of an urban environment is essential to any indicator. The immense size and structure of rapidly growing urban areas including mega- and meta-cities, those with populations of 10 million and 20 million people, respectively, and those with excess density make it difficult to assess the availability and accessibility of resources to the population.

Second, the WG noted a distinction between indicators of disaster early warning from those of disaster preparedness. Increasing rates of violent crime, reports of injuries and sexual violence may foreshadow a coming major conflict. In contrast, capacity of health centers to handle injured patients assesses ability to respond to such a crisis.

A final theme centered on ensuring the most accurate metric is used to for each indicator. For example, many current indicators rely on reporting percentages. In urban areas however, a small percentage of the population can represent a large absolute number of people. Indicators must include some measure of the absolute number of individuals and optimally specific categories of people affected by a given gap.

Areas of Proposed Metrics

1. **Health Outcomes**
2. **Physical Environment and Infrastructure**
3. **Governance and Response Capacity**
4. **Social and Human Development**
5. **Economics**
6. **Local Disaster Planning**

Health Outcomes

The WG believed that both structural and functional indicators of the healthcare system should be included. Outcome indicators of health should supplement standard structural indicators such as hospital bed capacity, human resources and drug supplies. For example, under-five mortality, overall mortality, or vaccination rates could be potential functional measures that offer insight into the existing state of a health system.

The development of health indicators could also include an assessment of existing mechanisms for reporting various forms of violence. Such systems are crucial for the management of this violence during a disaster. Indicators in this area could both assess disaster readiness and have potential early warning applications as discussed in above.

Physical Environment and Infrastructure

Poor infrastructure, inappropriate land use, and lack of structural standards can exacerbate a population's vulnerability to a disaster. As such, it is crucial to include an assessment of the existing infrastructure and the physical environment of a city when evaluating disaster preparedness.

Similarly, the population's current access to services is as important as the assessment of the physical infrastructure and thus defining resources such as sanitation, safe water, electricity, and fuel in terms of access rather than simply physical existence is another method for evaluating preparedness.

The physical layout and legal environment of property rights of a city influences the availability of temporary shelter, as a piece of land will be required. Thus, an emergency plan with pre-identified land available for setting up temporary shelter with an estimation of the capacity for that land should be considered for an indicator.

Governance and Response Capacity

There was a general consensus among the WG participants that the existing environment of governance structures and policies related to interactions with donors, aid agencies and international organizations involved in humanitarian relief are important determinants of humanitarian response. Indicators that represent this form of enabling environment could include mechanisms and policies the government has to coordinate with such organizations and channel donor aid. Fundamentally, basic response capacity measures such as the number of emergency response vehicles and personnel would need to be integrated into preparedness plans. In addition, some measurement of the capacity of the private sector to assist in a response should be included.

Social and Human Development

Existing levels of social development and cohesion have a profound influence on the impact of a disaster and how the post-disaster relief phase plays out. Many measures of social development, however, also fall into other basic heath or security indicators as they serve a dual role. For example, rates of child malnutrition could be used to reflect the developmental status of an individual city or neighborhood within a city. The best indicators to reflect these ideals still need to be determined but will likely draw from existing measures of development and social cohesion.

Economics

The structure of urban economies is incredibly complex with large informal markets interacting with the formal economy. The WG noted that this offers unique challenges and opportunities in disaster preparedness. Knowledge of all available existing supply chains could facilitate access to goods following a disaster. As discussed above, private sector capacity, if measured and understood before hand, can be utilized during disaster response.

Logistical Planning

The final area the WG identified as contributing to disaster preparedness relate to the city's existing disaster plans. The metrics could begin with a simple assessment if such a plan exists. If so, a second important component would be assessing the presence of budget resources allocated to researching, updating, distributing and executing the plan. Previous experiences have shown that vulnerable populations disproportionately bare the effects of disasters, and that this risk will worsen in the future. Identifying these populations and their susceptibility to various types of disasters, then developing plans to assist them is particularly important to disaster planning.

Future Directions

The power of integrating preparedness for complex humanitarian emergencies into urban planning is immense and must be harnessed. The UHAWG's discussions provide a starting point for future development of indicators on disaster preparedness for Urban HEART. Metrics on disaster preparedness would allow urban areas to evaluate their existing capacity for response and design targeted interventions to improve on their preparedness. The exact indicators still need to be further developed and refined. They will then need to be assessed to ensure they meet the principles of Urban HEART, which include ease of use, operational feasibility, generalizability and sustainability. The Harvard Humanitarian Initiative (HHI) and UHAWG along with the WHO will continue to develop and refine these indicators for final integration with the help of the WG over the coming year. Once developed and evaluated, these indicators have the potential to significantly expand the scope of the Urban HEART project, and may offer a standardized way for cities to improve their preparedness for the future humanitarian emergencies that will inevitably strike urban areas.

TRANSITIONING MENTAL HEALTH & PSYCHOSOCIAL SUPPORT: FROM SHORT-TERM EMERGENCY TO SUSTAINABLE POST-DISASTER DEVELOPMENT

Background

For various reasons mental health and psychosocial programs do not fit naturally into a purely "relief context." The current global shortage in mental health human resources means that "most mental health services are already understaffed and high-income country medical career and work structures are not geared to support mental health services in humanitarian settings." Additionally, short term relief interventions do not work well for mental health and psychosocial programming. Indeed, it has been pointed out that, "the 2-week in-and-out model of short missions by high-income country specialists – possible for surgical interventions—cannot be applied in the area of mental health." First, the recovery period for any patient with a mental health disorder is usually a minimum of six months, and in order to address the likelihood of relapse or provide treatment for those with severe disorders, a longer time period 18 months to 2 years is needed.

The objectives of social interventions, whether in transforming community attitudes towards marginalized groups, empowering groups of survivors, or changing educational practices in schools cannot be realized in weeks, or often even months. Survivors of traumatic events, particularly children and adolescents, may need to revisit treatment at different times in their development. For example, survivors of childhood sexual abuse might need to renegotiate traumatic reminders and symptoms that may occur as they become sexually active and begin to make decisions about intimate relationships as a young adult. In this manner, responses to traumatic events and subsequent treatment must be seen as a process that unfolds over time at a different course and rate depending on a number of individual, cultural and contextual factors.

Further, most of the work by expatriates is on-the-job training of local staff. Such training is labour intensive, time intensive, and does not contribute to sustainable clinical supervision structures. MHPSS programmes therefore need a longer term approach from the outset. However, funding streams usually differentiate between short and long term interventions, creating an artificial division between MHPSS programs in the emergency context, and those that focus on long-term development of services.

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The Working Group (WG) on Mental Health and Psychosocial Support participated in its second Humanitarian Action Summit in 2011. This year, the WG chose to focus on a new goal: reviewing practice related to transitioning mental health and psychosocial support programs from the emergency phase to long-term development. The Working Group's findings draw on a review of relevant literature as well as case examples.

The objective of the Working Group was to identify factors that promote or hinder the long-term sustainability of emergency mental health and psychosocial interventions in crisis and conflict, and to provide recommendations for transitioning such programs from relief to development.

Working Group Findings

The WG identified five key thematic areas that should be addressed in order to successfully transition lasting and effective mental health and psychosocial programs from emergency settings to the development phase. The five areas identified were as follows: Government & Policy, Human Resources & Training, Programming & Services, Research & Monitoring, and Finance.

While the discussion during the WG's sessions aimed to identify actions that would promote adequate long-term sustainability of programs, the WG initially opened discussion with a list of sometimes-common practice that may inhibit positive long-term benefits of mental health and psychosocial programs.

Do NOTs

- **Do not come in with pre-designed, culturally uninformed agendas and programs;**
- **Do not ignore existing government and non- government actors and systems;**
- **Do not ignore local capacity and experience;**
- **Do not parachute in with short-term interventions;**
- **Do not create stand-alone programs that drain staff and resources from existing services and cannot be integrated and sustained.**

Government & policy

Disaster or crisis intervention offers the international humanitarian community a unique opportunity to create new services, or reorganize and reform pre-existing ones, so that short-term support may be transitioned into sustainable MHPSS programs. Ideally, MHPSS policy should be

incorporated into the broader health policy and implemented at all levels of health care, so that MHPSS services are co-located and integrated with medical and social services delivery. Search for an existing strategy, framework, or policy in place. If one exists, work with the government to formalize mental health policy. If one does not exist, humanitarian actors must create one, working with a group from the government, NGOs and CBOs with experience in the area, national and regional service provision leaders, and relevant academic departments. Program designers must ensure that new programs or policies do not harm or undermine existing structures in a way that inhibits sustainability or quality of services.

Consider how, and to what extent, government should be involved. Government buy-in can be crucial to sustainability, but government participation should be carefully considered in situations where there are issues of poor governance or political sensitivity related to the provision of services. If key individuals officials or institutions are ineffective, corrupt, or do not support the enhancement of MHPSS services, efforts to involve government in the program development process could be detrimental. Even where a national policy framework exists, governmental decisions with respect to the allocation of state resources can seriously impact program implementation, and where governance is weak, policies may be disregarded by stakeholders. When there is conflict within government, program independence may be necessary to provide services that are neutral or depoliticized.

It is important to consider how government involvement in the provision and development of MHPSS services, once acquired, can be sustained over the long-term. Strong relationships between external actors and local stakeholders are necessary; but these relationships often take time, determination, and testing to develop. Agreements to sustain services may be formalized to ensure that program and policy implementation is institutionalized and sustainable over time, even in the face of changing government structure or shifts in political will. Efforts should also be made to develop the capacity of government to manage programs and services.

Human resources & training

Leverage existing human resources and understand management structures. This type of integration of MHPSS services into primary health care can optimize limited resources and thus promote sustainability. It is essential to identify providers who are genuinely interested in acquiring MHPSS skills. It is also important to determine whether potential trainees are able to make time for training, and are not overburdened with other work or training programs. Often, it is advantageous to seek trainees with previous MHPSS training or experience

Recovery periods for complex conditions are much longer and the risk of relapse is elevated. Patients initiated on treatment during the emergency period should be followed up for a minimum of one year. Training practitioners in the specialized interventions required to treat and manage such patients requires clinical supervision and extended follow-up. MHPSS training for complex interventions should consist of programs in which trainees are mentored and supervised by experienced practitioners over extended periods of time (ideally, 18 to 24 months).

Develop leadership and ensure professional support. In addition to training key service providers, the identification and training of leaders is crucial to the effectiveness and sustainability of MHPSS programs. Sound leadership and the ongoing support of professionals and providers can help ensure that the quality and effectiveness of programs are sustained along with the programs themselves.

Accreditation may help foster the development of more effective skills, encourage government and donor support and, consequently, enhance the sustainability of quality services. Where possible, the development of accredited certificate and diploma courses that are accessible to front-line workers in affected communities is strongly encouraged. The establishment of medical school departments of psychiatry and university departments of psychology, nursing, and social work is also central to the development of accreditation programs.

Train everyone at every level and develop sustainable supervision structures. It is essential that training take place at every level of the system. Training should be delivered to both service providers and management. Formal, long-term training of a core number of MHPSS 'helpers' should be designed on a national scale. Clinical psychologists or psychiatrists can supervise these MHPSS helpers, who may be trained within an action-research approach during the emergency period. Core skills to be taught would include psychoeducation, identification and referral, provision of interpersonal support, problem solving, and treatment compliance enhancement.

Programming & services

Sustainability in development requires addressing the whole system. For MHPSS services to be sustainable over the long term, it is crucial to think beyond programs and consider the system as a whole. Individual programs should be designed with respect to the implementation and development of an overall strategy that is holistic, integrative, and comprehensive.

Allow for different entry points for sustainable MHPSS services. To fully mobilize resilience and protective factors, it is important that multiple layers of intervention related to mental health and psychosocial support be integrated into broader health programs and delivered together. This psychosocial package should be comprised of several components, including practical support (e.g., medical services, food, water and sanitation assistance), community education about prevailing psychosocial problems such as substance abuse (to foster understanding and encourage self-help), community mobilization (e.g., stimulating cultural/religious leaders to re-assume their rolls, assistance with grass root initiatives), and community activities aimed at improving the general atmosphere, stimulating community action, and re-activating local customs and culture.

Consultation from various community stakeholders is essential. Comprehensive and sustainable MHPSS programs also require partnership with the affected community and beneficiaries, to foster the development of culturally acceptable services and promote a context in which the targeted community has a voice and can influence or determine the nature of the services provided. In planning MHPSS programs, it is particularly important to work in coordination with successful, established community services, avoiding duplication and using or expanding existing capacity where feasible. A smooth transition can be fostered through the formation of public-nonprofit partnerships, and partnering with relevant ministries and government services can ease the integration of new MHPSS programs with existing health and social welfare systems and help to ensure that resources to support programs will be maintained once the crisis intervention phase has ended.

Plan for long-term sustainability from the outset, even with short-term interventions. In situations where MHPSS services are to be temporary or time limited, it is essential that a phase-out plan be in place from the beginning and considered in the design of the program itself. Short-term projects that involve high numbers of staff or relatively highly paid staff are unlikely to be sustained, unlike those which use numbers and pay scales that are commensurate with local ability to pay. Where possible, MHPSS services that are initiated in response to an emergency situation should be integrated into existing community-based programs to increase their post-emergency survival potential. Particularly effective approaches include the linking of MHPSS services with community-based health programs (e.g., nutritional, HIV/AIDS, health education, sexual violence, reproductive health, safe motherhood and tuberculosis program activities) and the integration of trauma healing activities into basic education for children in post-conflict settings.

Do not forget to address neglected and vulnerable groups. Mental illness is not always perceived as a majority need, and it often remains hidden and silent due to stigmatization. It is important that MHPSS programs foreground the care of identified neglected and vulnerable groups whose extreme experiences require a holistic care plan including a precise clinical understanding and adapted, culturally acceptable strategies of intervention in post-conflict situations. Neglected and vulnerable groups in particular need of intervention would include survivors of sexual GBV (including male victims and observers), individuals with developmental delay, individuals with intellectual and physical disabilities, individuals with substance abuse problems, individuals with head injury damage and/or traumatic brain injury, former combatants, children, and the elderly.

Research, monitoring, & evaluation

It is necessary to combine service delivery and research. The WG has taken the unequivocal stance that assessment, monitoring and evaluation must be included in programming, and interventions or programs should be based on systematic research. This view is consistent with the past consensus statement of this Working Group in 2009, and the group's motto "*no survey without service, no service without survey.*" Program evaluation was specifically identified as a gap in existing research for mental health and psychosocial services. The group recognizes that there are inherent challenges to research, monitoring, and evaluation for mental health programs in the aftermath of conflict and in the initial stages of development, as documentation and systematic measurement can prove difficult. To address these challenges, the WG recommends that researchers and services providers document as much data as possible in order to help shed light on baseline needs. Cross cultural assessments of psychological problems and needs, cross-cultural validation of stress-related disorders, and cross-cultural assessments of the relevance of assistance offered must be further studied, with appropriate program evaluation, to determine which interventions are appropriate in a given setting. Ideally, good research, monitoring, and evaluation can inform constructive improvements in programming with long-term impact on beneficiaries.

Funding for continuing monitoring and evaluation is essential. Improving research, monitoring, and evaluation efforts as related to programming ultimately means seeking sufficient, earmarked funds to support monitoring and evaluation efforts. It may be the case that, at times, funding for research to evaluate programming is not available simply because research for funding is simply not sought or specified by those seeking funds. At the 2011 summit, one donor representative in the discussion group noted that proposals she reads often lack a section related to monitoring or evaluation, and that donors often look for even the most basic statements of

justification for monitoring and evaluation. Such statements need not be lengthy or intricately detailed, but they must somehow be present in the proposal.

One of the best measures of impact for a majority of MHPSS interventions is restoration of functioning at the individual or community level. In the aftermath of large-scale emergencies, repairing the social fabric of the community is crucial to recovery, as well as a good indicator of program success. Research efforts could better support the transition of emergency programming to development by focusing more on social consequences of mental disturbance, which may also help to identify subgroups most as risk of adverse outcomes if denied emergency treatment. However, working group members also discovered a paucity of research on the sustainability of interventions in these settings. Interventions were usually implemented over a relatively short time span of weeks or months, and studies differed widely with respect to the frequency and length of sessions, as well as the level of training and supervision provided to those administering. The lack of longitudinal research hinders our ability to understand what is needed to maintain initial effects.

Success is determined by the sustainability, acceptability, access, and impact of the given intervention. A sustained service that is neither fully accessible nor acceptable to the local population is of little use. Information concerning factors such as ease of access and local acceptability must be tracked from the outset of an intervention because without data, the argument for support by government and\or funders is less compelling, and common practices will not improve between disasters. In cases where services are intended to persist into the development phase from the outset, service providers should continue to monitor both effectiveness and feasibility as part of program activities. To adapt effectively, programs should continue to feed data into iterative changes and monitor their effect, which will require input from 1) the population (via rapid qualitative methods and/or meetings), 2) the government (via meetings), and 3) service providers or other interested parties (via meetings). Ultimately, mental health interventions should either save lives, make beneficiaries more functional, or improve quality of life.

Finance

Consider the costs: “Emergency funding” should be for a minimum of 1-2 years. The nature of mental health disorders, as well as lessons learned from successful MHPSS interventions, demand that interventions be funded for longer periods of time from the outset. With a few exceptions (e.g. psychological first aid), MHPSS emergency interventions generally require at least 1-2 years of funding to ensure that beneficiaries are served through

the length of their recovery time, that staff are trained to understand the full cycle of mental illness, and that genuinely responsive programs are developed, tailored to community needs. Very often, even where there exists government support or collaboration, the absence of a long term donor will mean an absence of community based services after closure of emergency services.

Large amounts of short-term money can sometimes do more harm than good. Even in situations where donors wish to provide funding for MHPSS relief, large amounts of funds could instead work to undermine existing, effective service providers who understand the local context, or could introduce interventions that are not proven to do more good than harm. The tight timeframes often led to an over-supply of costly short-term or superficial interventions (i.e. children's activity festivals), rather than the financing of long-term community mental health services.

Innovate mechanisms for reserving or investing money for long-term use. One concern about discouraging the short-term influx of vast amounts of funds to a particular region is driven by the reality that internationally resources are scarce, and the fear that if funds are refused or underutilized when offered, they may not be offered when needed in the future. This then raises the question, "Can we reserve or invest overflow short-term money to be used longer term?" There exists a need for innovative strategies and flexible funding to be presented in coordination with donors.

Conclusion

The working group was very conscious to address both mental health and psychosocial interventions. Despite the fact that the conceptual and practical differences exist between the two, the WG believes the two are not mutually exclusive, but can be layered to address beneficiary needs.

The list below draws on and builds upon action sheets 6.2 and 6.4 of the ISAC Guidelines. It serves as a reminder of points to keep in mind from the outset of planning for a community based MHPSS program, in order to foster long term development of accessible, impactful, culturally appropriate, and sustainable MHPSS services.

Ask:

1. *Have I assessed existing services including traditional ones to see how they are functioning and what support they need?*
2. *Have I met with local and international NGOS already active in this field to collaborate and coordinate?*
3. *Am I using local staff?*
4. *Have I involved existing authorities and stakeholders?*
5. *Am I integrating into existing service structures?*
6. *In the absence of points #3 and #4 (due to mass destruction and mass casualties- therefore necessitating use of outsiders), am I developing a transition strategy for handover?*
7. *Am I aware of existing national strategies for mental health, if they exist?*
8. *If none exists is the emergency an opportunity to create one?*
9. *Am I documenting everything I do and collecting data to contribute to the creation of baseline needs?*
10. *Can we create an emergency service that could be a model or basis for a long-term sustainable service?*

BEST PRACTICE GUIDELINES ON SURGICAL RESPONSE IN DISASTERS AND HUMANITARIAN EMERGENCIES

Background

The provision of surgery within the humanitarian context was first discussed during the 2009 Humanitarian Action Summit. The working group at that time developed the following recommendations focusing on three broad issues to improve the delivery of surgical care by humanitarian organizations: i) anticipate and understand the local context and conduct a needs assessment ii) incorporate best practices in the humanitarian delivery of surgery, and iii) incorporate data collection into humanitarian practice.

The objective of the working group for 2011 HAS was to build on the work of the previous summit, and further define guidelines for surgical and anesthesia provision by foreign teams and individuals in disasters and humanitarian emergencies. These guidelines will help facilitate coordination, cooperation, and collaboration, define scope of practice, and contribute to an ongoing dialogue on surgery and anesthesia best practices within the humanitarian community. Specifically, the goals and deliverables of the 2011 HAS working group were to:

1. Revisit the role of surgery in disasters, humanitarian crises, and conflict by reviewing the literature and developing consensus among experts in the field.

2. Define the role of international organizations (IO), non-governmental organizations (NGO), and military-led surgical assets in providing surgical services, and develop best practice guidelines for surgery and anaesthesia in disasters, humanitarian crises, and conflicts.

Prior to the 2011 Summit, the Working Group performed an extensive literature search examining the role of surgery in disasters and other humanitarian emergencies. The goal of the literature review was to guide the working group's discussion of pre-departure planning for the provision of surgical care in crises. Information was gathered on patterns of morbidity and mortality, patterns of disease, resources required, and the outcomes of surgical interventions in crises to better understand health services delivery. During 2011 HAS, a group of experts in the fields of surgery, anesthesia, emergency medicine, rehabilitation medicine (physical and psychosocial),

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engineering, and humanitarian delivery were invited to discuss the specifics of best practices for surgical delivery in the humanitarian setting.

Working Group Findings

Over the course of the HAS, a consensus opinion was achieved regarding the importance of the following fundamental themes in planning surgical relief efforts:

1. The importance of surgery and anesthesia in disaster relief and preparedness:
Providing early surgical care is crucial to an effective response in humanitarian emergencies. Appropriate surgical interventions, obstetrical care and anesthesia services should be identified as essential health services within disaster relief efforts.

2. Minimum standards for capabilities and competencies:
There should be a set of minimum standards for capabilities and competencies required of international organizations and individuals providing surgical care within disaster and conflict settings.

3. The multidisciplinary surgical response and adequate pre-deployment preparation:
Planning for a multidisciplinary surgical response and reception of these teams in disasters and conflicts must begin early. The team's mandate should be based on a needs assessment of the crisis-affected population, and should be reflective of the team's capacity, experience and capabilities.

4. Minimum standards required for program planning, equipment, medications, and range of services provided:
The following minimum standards of care provide a guideline for teams and individuals in setting up a surgical program that is self-sufficient, flexible and adaptable to the needs of the local environment and context. Prior to beginning surgical clinical care, the necessary building blocks must be in place to ensure that treatment is provided safely and competently.

Program Planning
Security - There needs to be an appropriate organizational-level response to an insecure environment, including situational awareness, contingency plans, evacuation capabilities and adequate resourcing.

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Electricity - Individuals and teams need to be self-sufficient in terms of meeting the energy demands required for delivery of surgical care.

Waste and Sanitation - There needs to be a safe and effective means of waste management, including a safe method of disposing of sharps and hazardous biological waste.

Water - It is recommended that teams plan for adequate water resources that exceed Sphere published minimums of 40-60L/day for a hospitalized patient if they undertake surgical activities. Sufficient water should be stored on the premises to ensure a steady and uninterrupted supply.

Sterilization - The sterilization method should be able to accommodate the variety and size of surgical instruments and equipment needed in the field.

Blood Availability - A living donor blood bank and the capability for ABO typing and screening for infectious diseases should be the minimum requirement for all operative procedures with more than a minimal risk of hemorrhage. Screening protocols should be tailored to local epidemiology.

Personnel- Teams should be composed of professionals who are experienced in triage, anesthesia, rehabilitation, and adult and pediatric general surgical, orthopedic and obstetric procedures. Core teams should be supplemented with other specialists if there is sufficient need on the ground based on assessments of population needs, available resources and gaps in service delivery. Auxiliary staff should include logisticians, translators, and health service managers.

Equipment

As a minimum standard of care in disaster settings and humanitarian emergencies, all equipment should be appropriate to the local environment and context, and suitable for transportation.

Oxygen Availability - Oxygen should be readily available for all surgical procedures, provided, at a minimum, by an oxygen concentrator.

Anesthesia Equipment - A pulse oximeter and a non-invasive blood pressure cuff should be available.

Surgical and Rehabilitation Equipment - Surgical equipment sufficient to perform the range of surgical procedures expected according to the disaster/conflict is required at a minimum. This should include equipment necessary for emergency obstetric surgery, trauma surgery, simple and complex wound care, and non-crisis related procedures. Teams that

provide post-operative physical rehabilitation should also have required assistive devices (e.g. prostheses) and mobility aids (e.g. wheelchairs and crutches).

Supplies - Personal protective equipment such as sterile gloves, gowns, masks, and eye protection are essential items and there should be a sufficient amount appropriate for the duration of the relief effort.

Medications

In the absence of evidence-based guidelines specific to disaster or conflict situations, refer to the World Health Organization's (WHO) Model List of Essential Medicines. Any augmentation to these recommendations should be considered with regards to continued sustainability and procurement means within the country, and existing formularies as applicable. Expired drugs should not be brought to disaster sites by humanitarian relief teams.

Anesthesia - Drugs and equipment for regional anesthesia (peripheral and neuraxial), procedural sedation, local anesthesia as well as general anesthesia should be included.

Antibiotics and Prophylaxis - Drugs that can appropriately cover the typical organisms responsible for surgical infections should be included. Knowledge of endemic infectious and non-communicable diseases is essential for both pre- and post-operative care and rehabilitation. Tetanus prophylaxis should be available and given where appropriate. Prophylaxis for endemic diseases should be available for clinical staff as well as patients. Staff should be up-to-date with vaccinations for endemic diseases, as well as those transmitted percutaneously such as Hepatitis B. Post-exposure HIV prophylaxis for needle stick injuries should be available.

Pain Management - The members of the working group reaffirm that access to pain treatment is a fundamental human right. Inadequate pain control is both inhumane and may result in increased morbidity or mortality. All modalities for pain management must be considered (pharmacologic and non-pharmacologic), and appropriate pre-operative assessment and post-operative monitoring is essential.

IV Fluids - Sterile, peri-operative intravenous fluids must be available. There needs to be a plan in place for a stable supply chain to obtain intravenous fluids, recognizing that the amount and type that can be transported initially may be very limited.

Range of services expected to be provided

Any operation or procedure performed should take into consideration the capabilities and limitations to providing effective and safe post-operative care and rehabilitation in that context. Existing evidence suggests that foreign medical teams and foreign field hospitals are likely to encounter a range of surgical pathologies both directly and indirectly related to crises.

5. Surgical medical record keeping including informed consent:

A medical record must exist for every surgical patient. Patient registration and documentation of all subsequent clinical activities is essential to the optimum management of the patient, and should have the capability to feed into host countries' local health information systems in an effort to build future capacity and coordination. The surgical medical record should consist of the following: Preoperative Assessment, Consent, Operative/Anesthetic Note, Post-Operative/Discharge Plan. These items form the core of the surgical medical record and should be in addition to any other hospital record the patient may have.

6. Minimum dataset for epidemiologic reporting of pathology, caseload and patient demographics, surgical outcomes and quality indicators:

There should be standardised reporting for epidemiologic investigation and sharing of information. There should be further examination of an operationally useful information system for prospective and retrospective analysis by examining the experience of other countries and organizations.

7. Minimum standards of post-operative follow-up care:

Every individual undergoing a surgical procedure must be seen for follow-up within an appropriate time frame by the treating team or designated care provider. It is the responsibility of the surgical treatment team to ensure this occurs. In humanitarian emergencies, the issue of follow-up becomes more complex given the often transient nature of the population served. A portable medical record system that can be used by a range of clinicians in different settings becomes all the more essential in these situations.

Conclusion

Given the crucial role of surgical care in the aftermath of disasters, surgical and surgical rehabilitation services must be viewed as essential health services along with other public health priorities such as shelter, food, clean water and sanitation. The normal high level of coordination involved in surgical care delivery is complicated by the realities of modern humanitarian emergencies, which involve an increasing number of actors providing humanitarian relief. The inclusion of care for the injured patient as an

essential health service in the most recent (2011) Sphere Handbook not only underscores the value of trauma, surgical services and post-operative rehabilitation for trauma-related injury in humanitarian activities, but also the importance of properly prepared and adequately trained surgical care providers. The development of surgical best practices within the humanitarian space will ensure accountability and quality of services for the delivery of surgical, anaesthesia and rehabilitative care.

How best to transition from short-term emergency surgical relief efforts to longer term health systems strengthening remains a key challenge for the global surgical community. Proper team planning, the provision of context appropriate medication and equipment, comprehensive surgical medical record keeping, surgical outcome reporting, and timely and appropriate post-operative follow-up are all important components that must be considered the minimum standard of care for any individual or group who will provide surgical services in disaster settings and humanitarian emergencies. It is the intention of this working group to launch an ongoing dialogue that will eventually move the surgical community closer to the evidence base required for robust best practice guidelines, to better prepare a future generation of surgical humanitarians.

Table 1: Existing guidelines applicable to humanitarian delivery of anesthesia or surgical care

Publication	Summary
Sphere Project Humanitarian Charter and Minimum Standards in Disaster Response (2011)[1]	Not specific to surgical services or delivery Broad guidelines and standards for the delivery of humanitarian relief
World Health Organization (WHO) Best Practice Guidelines on Emergency Surgical Care in Disaster Situations (2005)[8]	Extracted from WHO manual "Surgical Care at the District Hospital"[9] Describes basic clinical management of common surgical problems encountered in disaster ○ Resuscitation ○ Wound management ○ Fractures ○ Amputations Guidelines included for proper antibiotic usage, post-operative care and anaesthesia
International Committee of the Red Cross (ICRC) War surgery Guidelines (2009) [10]	ICRC publishes basic reference manual for surgeons embarking on humanitarian missions in settings of conflict since 1988. Comprehensive handbook on characteristics and mechanisms of war injury, epidemiology, triage, wound scoring, and clinical management of war related injuries. Guidelines on antibiotic use, principles of surgical management, and blood transfusions in resource limited settings.
WHO/PAHO Guidelines on International Foreign Medical Teams (2010) [3]	Minimum standards for medical teams and facilities after sudden impact disasters, focusing on health services provided rather than type of field hospital to be mobilized International registration as a first step to eventual accreditation of foreign medical teams
World Federation of Societies of Anesthesiologists (WFSA) International Standards for the Safe Practice of Anesthesia (2008)[11]	Best practices and standards for anesthesia delivery in all environments Not specific to disaster or humanitarian crises
WHO Guide to Anesthetic Infrastructure and Supplies at Various Levels of Health Care Facilities (2006)[12]	Extracted from WHO manual "Surgical Care at the District Hospital" [9] Details the various procedures and anesthesia training required at different levels of health facilities, and the essential medications and equipment appropriate at each level Not specific to disaster or humanitarian crises
American Society of Anesthesiologists (ASA) Standard Guidelines and Statements [13]	Website repository of the various published position statements and guidelines of the ASA on anesthesia best practices Not specific to disaster or humanitarian crises

Box 1: Surgical Issues Within the Humanitarian Space Working Group Summary

Statement 1: *Surgery and anesthesia are essential services in the crisis response, and along with rehabilitation, are part of the spectrum of care of the injured patient.*

Statement 2: *There should be minimum standards of core competencies and capabilities for providers of surgical care in crisis, to promote professionalization and standardization in the field.*

Statement 3: *Adequate planning for the surgical response in crisis should begin early, based on a needs assessment of the affected population.*

Statement 4: *There should be minimum standards of care in the following areas during planning of a surgical response in crisis:*

Program Planning	Equipment	Medications
Security	*Anesthesia Equipment*	*Anesthesia*
Electricity	*Surgical and Rehab Equipment*	*Antibiotics and Prophylaxis*
Waste Management	*Supplies*	*Pain Management*
Water		*Intravenous Fluids*
Sterilization	Services Provided	
Blood Availability		
Personnel		

Statement 5: *There should be a surgical medical record for every patient consisting of:*

***P**re-operative Assessment*
***C**onsent*
***O**perative Note/Anesthetic Record*
***P**ost-operative/Discharge Plan*

Statement 6: *There should be a minimum dataset to allow for standardized data collection for epidemiologic/field reporting of the surgical response in crisis.*

Statement 7: *Follow-up of the surgical patient should occur within an appropriate time frame, with the view towards long-term rehabilitation, prevention of disability, quality of life and community reintegration.*

CONSENSUS STATEMENTS REGARDING THE MULTIDISCIPLINARY CARE OF LIMB AMPUTATION PATIENTS IN DISASTERS OR HUMANITARIAN EMERGENCIES

Background

Limb amputations are frequently performed as a result of trauma inflicted during conflict or disasters. As witnessed during the recent earthquake in Haiti, coordinating care of these patients in austere settings is complex. The newly launched *World Report on Disability (WRD)* provides global guidance on implementation of the *UN Convention on the Rights of Persons with Disabilities (CRPD)* and has recently indicated that trauma care and rehabilitation services are essential services to be provided in humanitarian crises. The important implications of this report are highlighted when providing care to a patient undergoing amputation. The recent Haitian earthquake and the significant volume of patients requiring amputation in its aftermath highlighted the need for coordinated and standardized surgical and perioperative care in the humanitarian setting. Recommendations in best practices, standards, accountability and accreditation must be addressed in a timely and accurate manner.

During the *2009 Humanitarian Action Summit (2009 HAS*), the Burden of Surgical Disease Working Group (BOSDWG) published the following recommendations on the provision of surgery in humanitarian settings:

- Understand the local context by conducting pre-program needs assessment
- Incorporate best practices in humanitarian delivery of surgery
- Incorporate data collection into humanitarian practice

In 2011, a Surgical Issues Within the Humanitarian Space Working Group was formed in order to build on these statements and develop best practices for surgical care in disaster and conflict settings.

A separate 2011 HAS Amputations Following Disasters or Conflict Working Group was developed. During the Summit, the goals and deliverables of the Amputation Working Group were to:

1. Review the literature and develop consensus on the multidisciplinary approach to limb amputation, rehabilitation and peri-operative support following disasters and conflict.

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2. Define the role of international organizations (IO)/non-governmental organizations (NGO) and military medical services providing limb amputations in the field and establish consensus statements to encourage accountability, consistency, and quality of care of limb amputation patients in surgical humanitarian response.

Working Group Findings

Provision of humanitarian surgical care for limb amputation extends beyond the technical considerations of when and how to operate. Working group members unanimously agreed that the medical care of limb amputation patients involves a comprehensive, multidisciplinary approach as the patient progresses from initial triage, pre-operative assessment and resuscitation to amputation, prosthetic fitting, rehabilitation and eventual community reintegration. Working group members also affirmed that humanitarian surgical responders should provide appropriate post-operative and follow-up care for amputation patients. Such care involves management considerations consistent with the care environment and available medical resources.

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Consensus Statements

Providing appropriate care to the patient undergoing amputation in the humanitarian setting means expanded planning for a multidisciplinary surgical care team. Along with surgical and anesthesia providers, this team should include access to, and early ongoing coordination with, personnel trained in rehabilitation and mental health services.

A medical record must be established for all limb amputation patients undergoing care in a disaster setting or conflict zone. Due to the long-term and multidisciplinary nature of their recovery and follow-up, patient registration, clinical record keeping including the post-operative discharge plan are critical for patients undergoing limb amputation. The lifelong implications of amputation must be effectively communicated when obtaining consent. The presence of rehabilitation professionals should be emphasized, as they are well qualified to properly describe the expectations in terms of functional recovery through prosthesis fitting.

Provision of effective anesthesia and analgesia for surgical care of limb amputation patients in a disaster setting or conflict zone is a fundamental human right. Pre-deployment planning for anesthesiologists must give rigorous attention to the equipment, pharmacy and support limitations that will be present in austere clinical settings. As such, total intravenous

anesthesia (TIVA) and ultrasound based regional anesthesia techniques (USRA) may be ideally suited to the clinical care of limb amputation patients in disaster settings or conflict zones. Multimodal prevention and management of peri-operative somatic pain and phantom limb pain (PLP) remain priorities for these patients who will need to be successfully reintegrated into their communities with future, self-supporting livelihoods.

The surgical care provider must recognize that there is an early window of opportunity for limb salvage. Surgical decision-making regarding amputations must account for limitations in supplies, availability of blood for transfusion, technical expertise, availability of rehabilitation services and prostheses, as well as cultural implications for the patient. If and when the decision of amputation is made, the goal is to optimize function by preserving appropriate limb length. War injuries present differently from those incurred by civilians during disaster and may require more staged intervention. Guillotine amputation is rarely indicated except as a last resort for emergency extrication and should not be used as a stand-alone solution.

Optimal rehabilitation of the traumatic amputee requires a comprehensive approach that considers medical/surgical, physical rehabilitation, psychosocial and community integration interventions. Appropriate, effective surgical care requires interdisciplinary team assessment and management involving rehabilitation providers from prior to surgery through community referral and follow-up. Due to the relative lack of rehabilitation providers and the acuity of crisis settings with the resulting need for task shifting, surgical providers should understand general, key principles of amputation patient rehabilitation. The patient's family, other caregivers and the community also must be actively involved in providing multi-layered rehabilitation across the continuum of care.

Clear post-operative discharge planning and follow-up course should be delineated for each amputee. Optimizing function prior to release from the hospital will provide the best potential for outpatient recovery. Patient and family education opportunities must be recognized.

In order to move toward improved humanitarian surgery data collection, there are surgical outcomes specific to amputation that should be developed. We considered the following:

Operative: wound infection, wound dehiscence, number of operative procedures, number of stump revisions, limb length

Post-operative: pain control, time to initiation of rehabilitation, use/satisfaction of prosthesis, use of assistive technologies, completion of activities of daily living

Suggested Strategies and Next Steps

During the 2011 HAS, the Surgical Working Subgroup on Amputations Following Disasters and Conflict developed multidisciplinary consensus statements for amputation, post-operative management and rehabilitation following disasters and conflict. Further discussion between invested international aid organizations and other humanitarian stakeholders including international medical professional societies and the World Health Organization (WHO) is required.

Such discussions will help formalize our consensus statements into multidisciplinary practice guidelines with the aim of improving the quality of management of amputations in humanitarian settings. Preliminary steps are already being taken by the newly proposed Emergency Surgery Coalition, a consortium of surgical providers aiming to standardize and maximize delivery of humanitarian surgical assistance. Development of uniform multidisciplinary guidelines will compel the humanitarian surgeon and surgical team to observe a higher professional standard of care. Most importantly, life-saving amputations during crisis will grant patients more satisfying, productive lives and help establish a healthier post-crisis society.

Conclusion

Ample discussion within the humanitarian community is required in order to identify and promote best practices for multidisciplinary amputation care in disaster and humanitarian emergencies. The 2011 HAS Amputation Working Group has presented recommendations in the areas of team planning, medical record keeping, operative technique, pain management, rehabilitation, follow-up and outcomes tracking. Further dialogue is needed in each of these areas and will move us toward the evidence base required for advancing surgical care delivery during crises.

Increasingly, the responsible humanitarian surgeon will be required to understand not only surgical principles of amputations, but also to be mindful of what lies beyond the operating theatre for each patient: a lifelong battle with pain control, functional recovery and psychosocial reintegration. Multidisciplinary care must be planned and prepared for even in the post-disaster and conflict setting. Without working towards a full spectrum of care in low-income settings, a life may be initially saved by amputation surgery, but lifelong disability is certain. The time is now to continue this discussion, and to plan for the next disaster or conflict that will call us to action.

Table 1: Summary of Guidelines Reviewed

Sponsoring Organization	Guideline
World Health Organization	*WHO Best Practice Guidelines on Emergency Surgical Care in Disaster Settings*
	WHO Surgical Care at the District Hospital
International Committee of the Red Cross	*War Surgery Vol 1*
	Surgery For Victims of War
United States Army Medical Department Borden Institute	*Care of the Combat Amputee (book)*
International Campaign to Ban Landmines (ICBL)	*Working Group on Victim Assistance. Guidelines for the Care and Rehabilitation of Survivors*
Amputation Coalition of America (ACA)	*Experts Consensus on Amputation Techniques for War Injuries*
Amputation Surgery Education Center (ASEC)	*General Principles of Amputation Surgery*
Handicap International (HI)	*The rehabilitation of amputees victims of landmines*
United States Veterans Affairs Department of Defense	*Clinical Practice Guidelines for Rehabilitation of Lower Limb Amputation*

Figure 1: Multidisciplinary approach to amputation patient

Box 1: Amputations Following Disasters or Conflict Surgical Working Group Summary

Statement on Team Response: Expanded planning for a multidisciplinary surgical care team**.**

Statement on Medical Records: Clear, interpretable, culturally-sensitive obtaining of consent and thorough post-operative record keeping.

Statement on Anesthesia and Pain Management: Access to anesthesia and analgesia is a human right. TIVA and USRA are ideal considerations in austere settings. Multimodal management of somatic and phantom limb is a priority.

Statement on Surgical Services: Early window of opportunity for limb salvage or optimize function by preserving appropriate limb length. Guillotine amputation is rarely indicated.

Statement on Rehabilitation Services: Involvement from prior to surgery through to community referral and follow-up. Task shifting between available providers and family/caregiver(s) education is necessary.

Statement on Discharge and Follow-Up: Clear plan and optimize function prior to discharge.

Statement on Surgical Outcomes: Operative and post-operative amputation-specific outcome measures to develop consistency in care.

INNOVATIONS IN HUMANITARIAN TECHNOLOGIES

Background

Over the last decade, the global rapid rise in the use of information and communication technologies (ICT) for individuals and communities has posed both promising opportunity and significant challenges for organizations engaged in crisis and disaster response. The 2009 Humanitarian Action Summit (HAS) convened a range of humanitarian stakeholders engaged in exploring the evolving role of ICT—particularly the application of mobile communications, satellite imagery, and mapping—to humanitarian crises and disaster response. The HAS working group (WG) is composed of experts versed in these technologies and their potential for operational field applications as well as humanitarian practitioners who have operational experience with a general understanding of ICT applications.

In 2010, OCHA and the United Nations Foundation and Vodafone Foundation commissioned the Harvard Humanitarian Initiative (HHI) to help the information cluster lead formulate a framework that would integrate evolving information and communication technologies and the rapidly evolving volunteer community that employs them into the formalized humanitarian response operations. This integrating framework study—titled *Disaster Relief 2.0*— was an analysis of forty interviews from information management key informants intimately engaged with the Haiti response; the study informed the objectives and became the basis for discussion and recommendations of the 2011 HAS working group.

Framework

The information management that occurs in a crisis—the gathering, processing, and dissemination of data into information that guides a timely, meaningful, targeted, effective humanitarian response activity—remains a constant, and thus, unifying objective among all stakeholders regardless of the evolutionary changes in ICT. Largely the domain of the UN's Inter-agency Standing Committee led cluster system, information management is conceptually a "rate-limiting step" in the effort to gain humanitarian response situational awareness:

- it commences as close to the triggering event as possible,
- synthesizes large amounts of disparate and usually incomplete and often inaccurate data, and

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- attempts, through multiple iterations of analysis, to get in front of the humanitarian juggernaut that is hundreds of response organizations with thousands of personnel responding to acute needs.

Information bottlenecks, delays, and inaccuracies often leave a perilous vacuum in which humanitarian responders arrive and direct resources haphazardly and real population needs remain unmet. If, in the course of crisis-evolving time, this vast quantity of data leads to information that congeals to actionable knowledge, it is often appreciated beyond the time of its usefulness and typically during a "lessons learned" analysis much later.

With Haiti fresh in mind, the *Disaster Relief 2.0* key informants identified major themes to consider for future humanitarian information management:

1. **Information gaps.** The quality of in-country baseline datasets determines the ability of responders to make comparisons with new ground data needed to direct resources in the immediate response.
2. **Information fragmentation**. For the purposes of cyber-security and individual protection, the clusters' closed proprietary systems lock data in tools and formats not easily shared across clusters or with the greater humanitarian community.
3. **Enhanced tools and capacities of the ICT community.** In particular, the technologies that enabled crowdsourcing—collaborative platforms with open interfaces that could mash up data stored in the platform on web services—can organize and manage collective intelligence for improved decision making during a crisis.
4. **Information overload on an inadequately tooled system.** With the potential for innumerable sources of information, the velocity and volume of information can overwhelm the capacity of field responders to validate and manage it despite increased investment in bandwidth and connectivity.
5. **Integration.** While every crisis theater of operations will differ, the need for the ICT community and UN cluster agencies to share information and communicate effectively will be a constant. Ideally this would entail a common set of protocols that would connect people, work flows and data flows.
6. **Enhanced expectations.** Rapid access to information through new ICT has generated high expectations from decision makers outside the crisis zone whose presumptions for rapid analysis, briefings, and operational response can further overwhelm field information management capacity.

Working Group Findings

With the *Disaster Relief 2.0* study as the springboard for discussion, the WG elaborated on the information management and integration challenges delineated above.

In regards to humanitarian decision-making: who needs to know what, where, and when?

Working group members from across the operational spectrum stressed the need for essential consensus-driven standardized data that reflect the emergency time course. Data defined by the humanitarian community as necessary for problem solving in each sector and phase (and for informational products) could be managed in a common free (non-proprietary) formatted operational dataset, easily accessible and shared. Challenges that remain include identifying disaster-specific data needs and the contexts that define them, building the technical capacity of the local population who provide critical core data, understanding how users use it and whether it makes a difference for the affected population in a crisis, and determining what security and protections need to be in place before data can be 'openly' shared. The WG stressed the need for trusted and secure networks of individuals whose information simultaneously embraces local knowledge (with critical translation as needed) and lends itself to 'ground-truthing'.

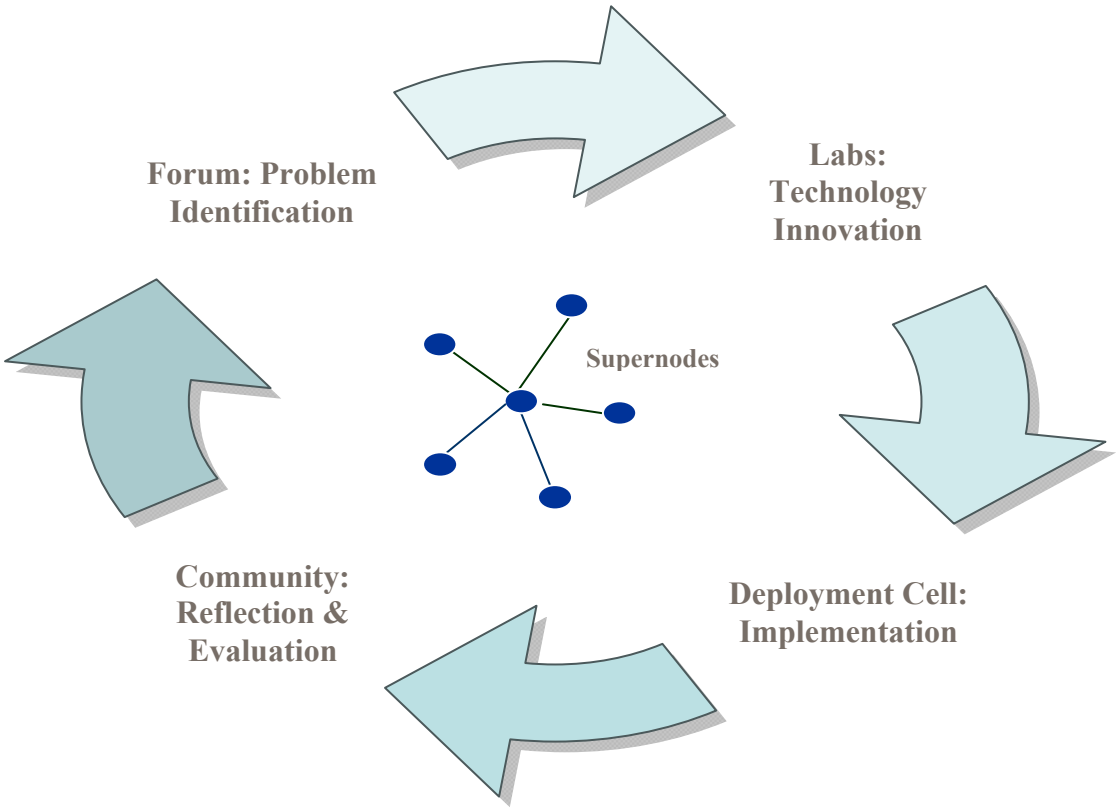
In regards to data systems - how to manage, integrate?

The cluster's information management capacity to deal with these facilitated data flows – to process and analyze large files of imagery, to exchange information with partnering volunteer technical organizations, to receive tens of thousands of individual calls for help from affected communities—will likely require a workable engagement with the humanitarian volunteer ICT community.

Recommendations

The WG debated a four element design proposed in *Disaster Relief 2.0* that would serve as distinct open and neutral conventions for discussing, hypothesizing, testing, and evaluating ICT integration in the humanitarian sphere. Within these four elements participants from across the humanitarian ICT spectrum would explore problems; test solutions; experiment without the fear of failure and its implications; provide feedback; and, archive lessons learned, all in the overarching interests of ICT for humanitarian operations.

Figure 1: Four elements for ICT in humanitarian operations



The Forum. The WG envisioned an open inclusive neutral space for idea sharing and problem-focused discussion. This 'safe space' would allow for organizational and integrative field challenges to surface and potential solutions to emerge that could be developed for field-testing in the laboratory element. Information managers, technologists, academics, donors, and experienced local community disaster managers would populate this space to begin to understand their respective operational mindsets and perspectives, and in so doing, engender trust. The Forum could begin to tackle the cultural and organizational impediments to integrating ICT in humanitarian operations as well as the technical challenges discussed above.

Humanitarian lab. The WG envisioned a physical space where field problems and their potential solutions—born from the Forum—could be tested, and where technical issues and tools could be fleshed out in advance of future crises. This element would likely include multi-disciplinary

exercises and simulations inherently designed with evaluative components to determine what succeeds and fails in varying contexts. Lab initiatives would consciously include global and local partners, especially members of populations where future crises are likely to occur.

Deployable cells. The WG described groups with multidisciplinary skills who would field test the applications of information tools, and while doing so, teach them, deploy them, and build local and organizational capacity around them. This element would implement and apply forum-generated and lab-tested innovations in real field environments. Such deployed teams would draw from across the specialized tasks that define information management and liaise with information managers within the UN cluster and the voluntary technical community as crises unfold.

Consortium. The academic consortium would systematically evaluate and archive the integrating process, technologies, and applications using a range of methodologies for the larger humanitarian stakeholder community. At its core inclusive, the consortium will encourage links amongst academics, practitioners, and specialists across multiple disciplines. Interuniversity partnerships can leverage their respective strengths, promote developing and developed world relationships, and work toward building the evidence base for the implementing and translating strategies that emerge from the lab and task force. The results of formal evaluation study and consortia evidence-based work will continue to trigger new discussion and debate around evolving ICTs or revised approaches within the Forum.

Conclusions

In the end, the UN cluster and the established humanitarian community will need to take defined steps toward integrating ICT in an effort to improve outcomes for affected populations in humanitarian crises. The momentum developed through the Haiti response, the crisismappers network, this WG, and the problem-solving volunteer technical community in general will continue to transform humanitarian operations.

HEALTH DIPLOMACY AND HUMANITARIAN ACTION: UNCHARTED TERRITORY

Humanitarian emergencies capture the public's attention. Television images and newspaper stories convey scenes of innocent civilians fleeing violence, the devastating and indiscriminate impact of natural disasters, and the life-saving interventions of health professionals.

Behind these images of humanitarian action lies a complex machinery of multilateral agencies, transnational non-governmental organizations, donor governments, and national-level agencies. While these actors are united by the objective to alleviate suffering and improve population health, humanitarian engagement is not without acrimony or debates regarding its effectiveness.

Key debates include how to enhance the professionalism of humanitarian actors; how to increase coordination and collaboration among international and national actors without undermining humanitarian principles of independence and neutrality; the role of the military and private security firms in humanitarian action; and how to increase efficacy of humanitarian response in diverse operational environments, such as urban settings.

The active engagement of humanitarian professionals in applied research is critical to addressing these debates and improving the humanitarian response. The Harvard Humanitarian Initiative's (HHI) *Humanitarian Action Summit,* held March 4-6, exemplifies such engagement. The Summit attracts practitioners currently active in humanitarian settings, together with researchers and government officials. The Summit is unique, combining expert presentations with the creation of working groups where participants collaborate to share and develop solutions to overcome those challenges. Working groups continue their activities between Summits, facilitating ongoing collaboration and professional development among participants.

HHI's Working Groups

Evaluations of major humanitarian responses, from Rwanda to Haiti, have pointed to the lack of professionalism among many humanitarian actors as a key impediment to more effective humanitarian action. Many humanitarian actors lack adequate training on how to provide emergency assistance, and have little knowledge of humanitarian norms or standards. HHI's working group on Professionalizing the Humanitarian Response has been active for

several years. To enhance humanitarian professionalism, they argue that an individual accreditation system was needed to develop a global association of committed, accredited individuals with basic competencies.

The working group on NGO Security and Staff Protection examines the perception of increased risk for humanitarian workers, acknowledging that while some deaths and injuries are a result of deliberate targeting, others are the result of humanitarian workers being bystanders in dangerous contexts. The working group will continue to analyze mechanisms to compile and share security information, and examine variance in casualty rates across organizations and humanitarian settings.

The Urbanization and Humanitarian Emergencies group analyses how to effectively address the needs of the humanitarian population in urban environments. Cities present many challenges to humanitarian response – including security, how to identify and differentiate the humanitarian population from the host population, the generally poor living conditions in many urban areas, and how existing humanitarian norms and standards can be translated for urban areas. This group is adapting the Sphere Guidelines to urban settings as well as systematically examining the coordination and security challenges of working in these environments.

The group on Field Level Coordination among Civilian and Military Humanitarian Actors works to identify and describe effective coordination techniques. They will examine how to institutionalize best practices while recognizing the constraints of the constant turnover of military staff and humanitarian personnel. The working group on Humanitarian Technologies, Crisis Mapping and Challenges in Information Management discusses how to harness the use of these technologies in the humanitarian response.

The group on Surgical Issues in the Humanitarian Space assesses the critical need for surgical expertise in humanitarian settings, but notes that the majority of surgical needs are a result of non-conflict related causes. Another working group on Mental and Psychosocial Support in Crisis and Conflict examines and identifies key knowledge gaps regarding mental health in emergency settings. Their work is guided by the following principle: no mental health survey without service and no service without a survey.

The Summit also announced the formation of future Working Groups, including a group on Post Conflict Health System Reconstruction, which will examine if and how humanitarian actors can better support national capacities and interface with the local health system. The working group on Clinical Care in the Field will examine how to improve the effectiveness of the clinical component of humanitarian action, while another group

examines the response of the humanitarian community to food security and hunger.

Throughout the course of the Summit, participants expressed frustration that humanitarian actors are unable to influence the political decisions that ultimately shape and constrain humanitarian engagement. While HHI's Working Groups can develop guidelines and best practices, the pathways to translate this guidance into action at the international level remain unclear. Research that identifies how humanitarian assistance could be more effective does not find its way into international policy.

Making Policy: Health Diplomacy in Humanitarian Emergencies

Humanitarian actors have been important participants in global processes surrounding technical norms, such as the Sphere Guidelines. However, humanitarian actors point to critical decisions on humanitarian action that are made in diplomatic forums out of the reach of humanitarian professionals. These forums lack transparency and are not subject to appropriate scrutiny or input from those engaged in the humanitarian response.

While diverse definitions of health diplomacy exist, health diplomacy is basically the mobilization of states, international organizations, and non-state actors in response to global health challenges. Although few humanitarian emergencies have an impact on 'global health,' the response to these emergencies is global in nature. Natural disasters frequently overwhelm the state, particularly in countries with low capacity. Conflicts either implicate the state, or reflect its fragility. As a result, multilateral agencies and international non-governmental organizations provide direct health assistance to reduce mortality and morbidity of the civilian population.

As of November 2010, the United Nations Office for the Coordination of Humanitarian Assistance (UN OCHA) estimated that 49 million people required humanitarian assistance. In 2009, over 15 billion USD was dispersed in humanitarian assistance; governments contributed 11 billion USD while private contributions reached 4.1 billion USD. Health assistance accounts for approximately 10 percent of humanitarian funding.

Humanitarian action, including the provision of health assistance, is characterized by multiple levels of diplomacy. International humanitarian action is governed by global norms and international humanitarian law, which include principles outlined in United Nations General Assembly Resolutions, agreements reached in multilateral forums such as the Inter-

Agency Standing Committee, and the Geneva Conventions which apply to humanitarian action in war-torn countries.

Multiple actors engage in health diplomacy at various levels during humanitarian operations. Negotiations determine the amount of assistance, how that assistance is delivered, what actors are engaged in delivering that assistance, and how to access crisis-affected populations. This diplomacy takes place in multilateral, bilateral and local settings and involves state as well as non-state actors. At the global level, diplomacy plays a role in determining the allocation and scale of resources as well as the technical standards for health interventions. Locally, negotiations determine how assistance is coordinated, the degree to which technical standards and international humanitarian law are upheld, the engagement of the military, and the role of national governments and other national stakeholders.

As a result of this complexity, humanitarian decision-making is opaque. Further analysis is needed to examine diplomacy among the various actors engaged in the delivery of humanitarian assistance, how humanitarian norms govern these interactions, and how these negotiations affect humanitarian assistance. More research needs to be done on health diplomacy in humanitarian operations to determine the key decision making forums, the actors who make these decisions, and the information that shapes the decision making process.

Influencing Diplomatic Processes: Part of the Professionalization Agenda

While the need for research on health diplomacy in humanitarian action is clear, humanitarian actors should not wait for the results of that research to take action. To ensure that the voice of humanitarian practitioners is reflected in global humanitarian decision-making, these practitioners need to develop the skills to engage and influence diplomatic processes at both the global and local levels. They will need training in negotiation and advocacy to influence the decision-making of multilateral organizations, among donor and recipient states, and among local actors. These skills will enhance the ability of humanitarian actors to achieve their objective of reducing suffering and improving population health. Current efforts to develop professional standards for the humanitarian community should expand beyond technical skills to include training in health diplomacy that enhances the effectiveness of humanitarian action.

SUMMARY REMARKS

The Humanitarian Action Summit, now in its fourth year, was developed to address major points of need and controversy in the humanitarian field, to establish a dialogue among practitioners and humanitarian strategists, and to promote discussion about complex and controversial issues that face the humanitarian community. This publication is a detailed review of the goals, deliberations, and recommendations of the working groups, concluding with an analysis of future needs. The authors hope that the Summit, and the resulting action points, serve as a launching point to advance the professionalism, quality and accountability of humanitarian intervention.

REFERENCES AND RESOURCES

Refer to the articles published in Prehospital and Disaster Medicine for all references and resources.