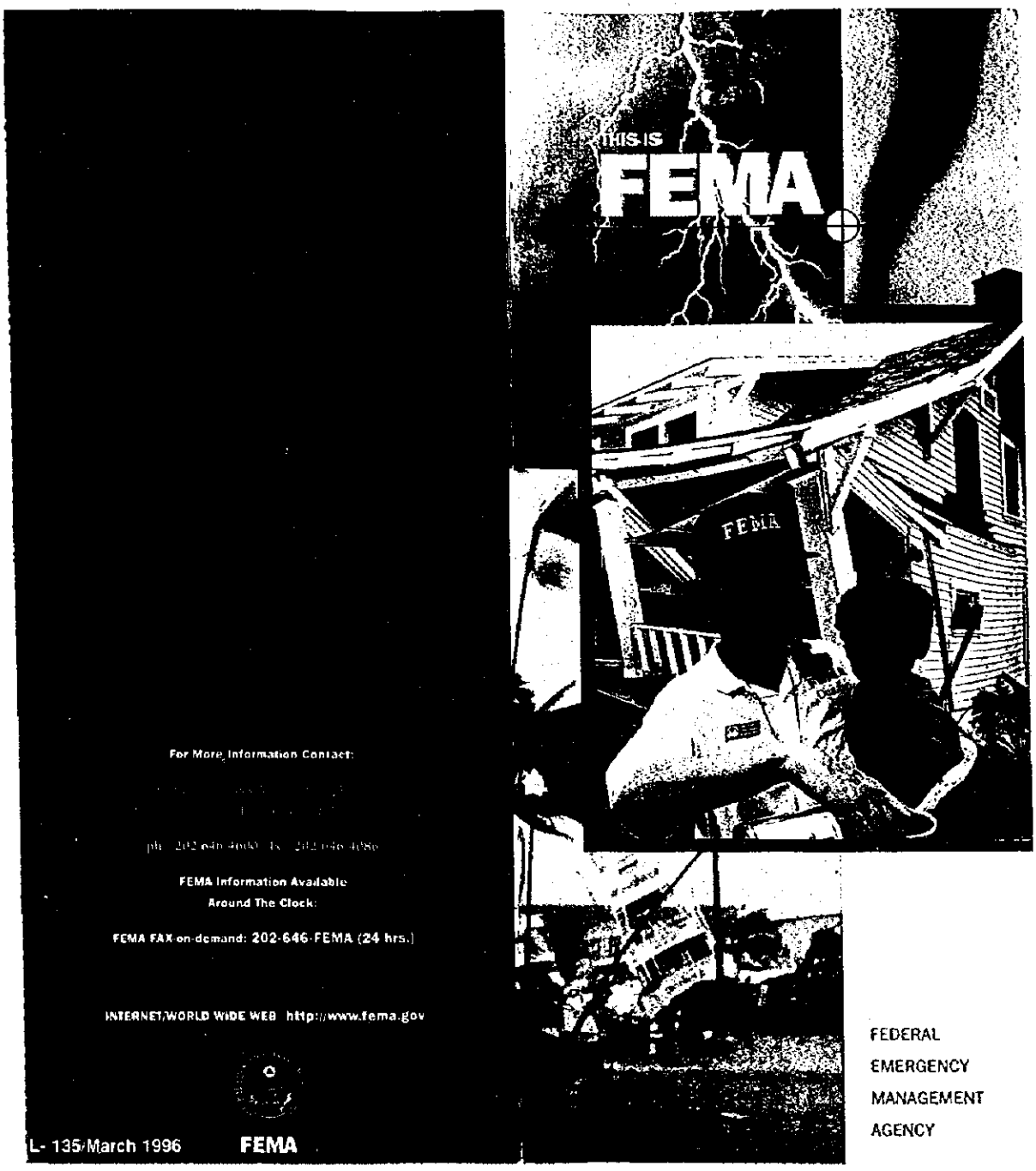
(5) FEMA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FEMA
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For More Information Contact:
FEMA Information Available
Around The Clock:
FEMA FAX-on-demand: 202-646-FEMA (24 hrs.)
INTERNET,WORLD WIDE WEB http://www.fema.gov
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FEDERAL
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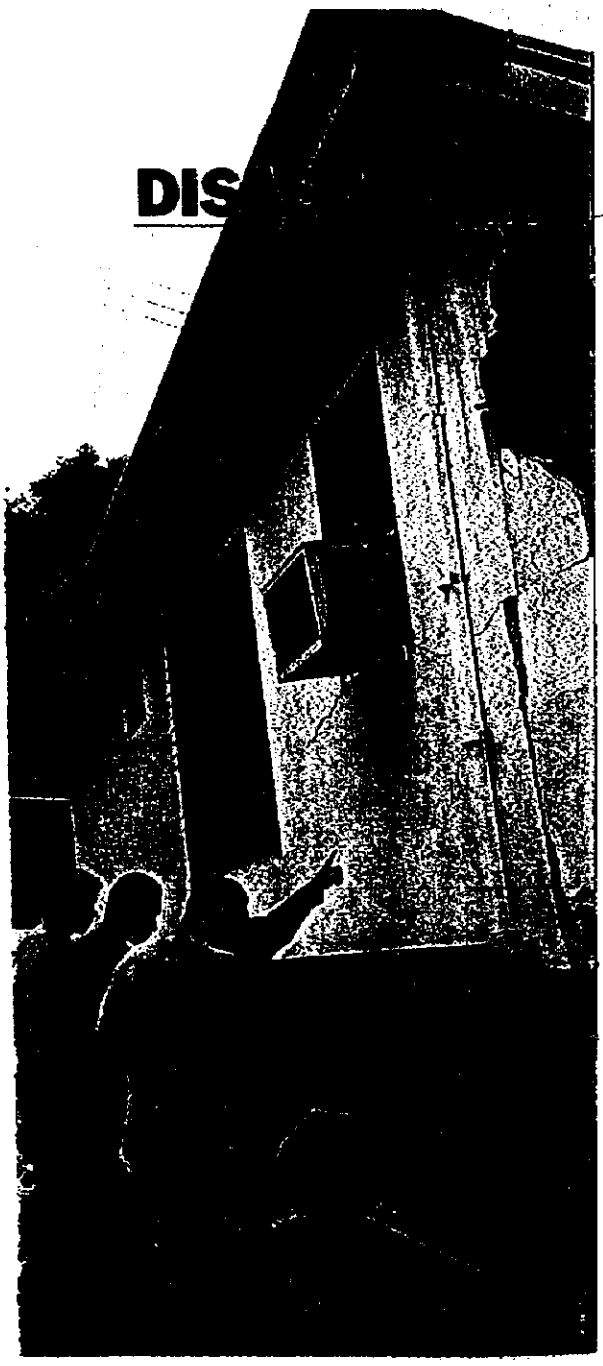
AGENCY



DIS

It strikes anytime, anywhere.

It takes many forms — a hurricane,

an earthquake, a tornado...

a flood, a fire or a hazardous spill...

an act of nature or an act of terrorism.

It builds over days or weeks,

or hits suddenly, without warning.

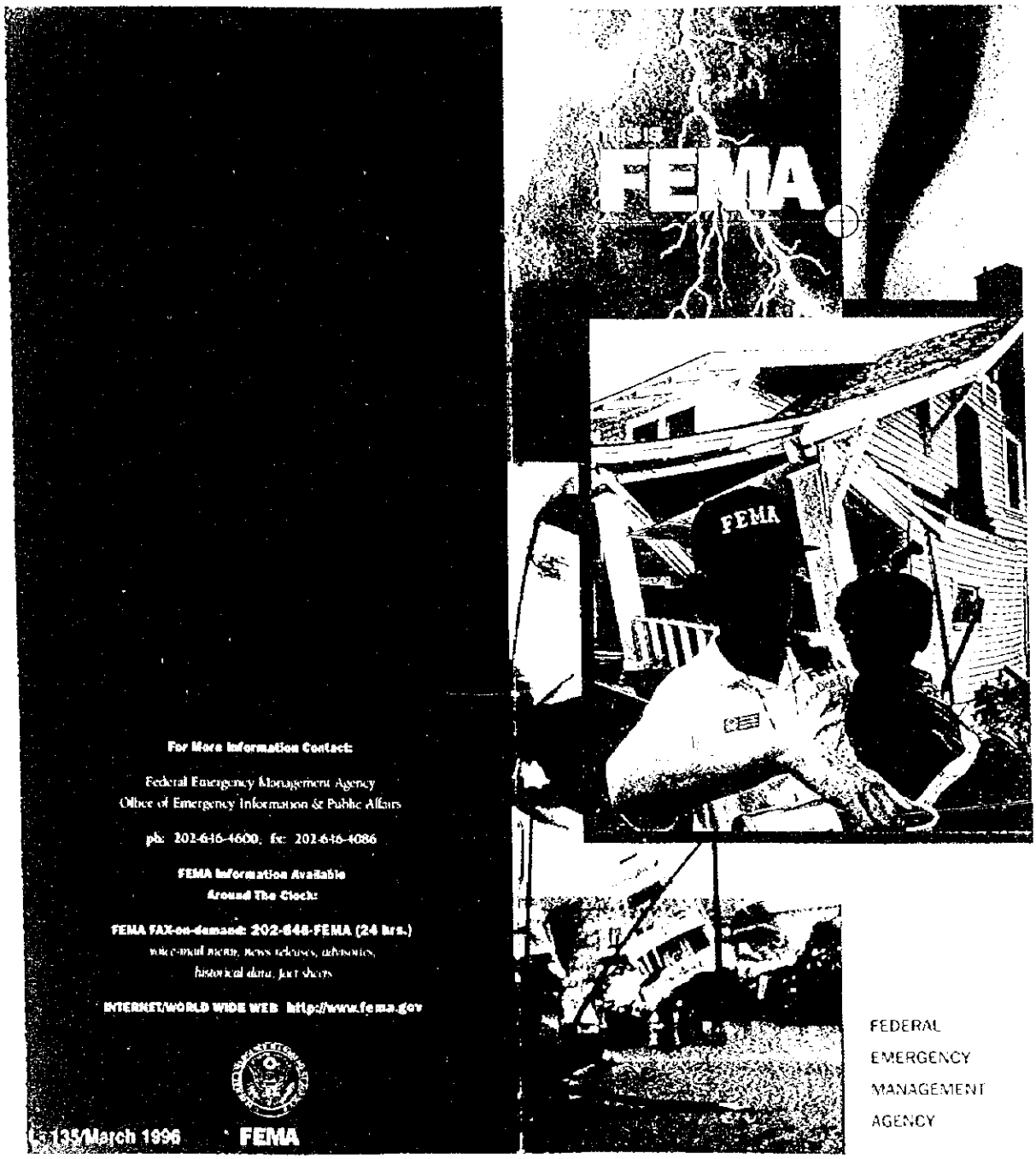
Every year, millions of Americans

face disaster, and its terrifying

consequences.

FEMA Helps

1



For More Information Contact:

Federal Emergency Management Agency
Office of Emergency Information & Public Affairs

ph: 202-646-4600, fx: 202-646-4086

FEMA Information Available Around The Clock:

FEMA FAX-on-demand: 202-646-FEMA (24 hrs.)
wide-ranging menu, news releases, advisories, historical data, fact sheets

INTERNET/WORLD WIDE WEB: http://www.fema.gov

L-135/March 1996 FEMA

FEDERAL
EMERGENCY
MANAGEMENT
AGENCY

DIS

It strikes anytime,
anywhere.

FEMA
Helps

The Federal Emergency Management Agency — FEMA

is an independent agency of the federal government, reporting to the President. Since its founding in 1979, FEMA's mission has been clear:
to reduce loss of life and property and protect our nation's critical infrastructure from all types of hazards, through a comprehensive, risk-based emergency management program of mitigation, preparedness, response and recovery.

Before, during and after major disaster occurs, FEMA is there, ready to help.

Vision

- A knowledgeable public able to protect themselves, their families, their homes and businesses.
- Structures located out of harm's way and built to withstand the worst.
- Governments and private organizations with plans in place and the resources and training they need.
- Communities capable of recovering and rebuilding after disaster has passed.

The People of FEMA

FEMA has more than 2,600 full-time employees working at FEMA headquarters in Washington, DC, at regional and area offices across the country, at the Mount Weather Emergency Assistance Center in Virginia, and at the National Emergency Training Center in Maryland. In a major disaster, as many as 4,000 temporary and reserve employees and volunteers may join the response and recovery team.

FEMA employees partner with state and local officials and the private sector.

Response and Recovery

When it becomes clear that a hurricane or other potentially catastrophic disaster is about to occur, FEMA moves quickly. Equipment, supplies and people are pre-positioned in areas likely to be affected. That way response can begin without delay.

Whenever a disaster strikes with such force that local and state resources are overwhelmed, a state may ask the President for federal assistance. This help is available

from a special fund set up by Congress under the Robert T. Stafford Act. In a Presidentially declared disaster, **FEMA helps** by:

- Assessing the damage and deciding what is needed.
- Making disaster aid available and managing the process of loan and grant application, approval and disbursement.
- Creating and staffing federal/state disaster field offices and coordinating other federal agencies' involvement under the Federal Response Plan.

- Keeping the public informed through a FEMA-published newspaper, *The Recovery Times*, through internet postings and through up to 24-hour-a-day broadcasts on *The Recovery Channel* and the *FEMA Radio Network*.
- Identifying opportunities to mitigate future disasters.

Disaster recovery centers are often set up in neighborhoods hit hard by a federally-declared disaster

Disaster Aid Programs

There are two types of aid:

- **Governmental assistance** — to state or local governments and certain private non-profit organizations, for repair of infrastructure and public facilities and for debris removal.
- **Individual assistance** — to citizens, for damage to residences and businesses or personal property losses.

Multilingual counselors help citizens apply for financial assistance.

After a Presidentially declared disaster people can apply for assistance quickly by calling a specially announced toll free number. FEMA may also set up Recovery Centers to assist people. Federal program assistance includes:

- **Housing assistance**, in the form of rental assistance, transient accommodations or funding of limited emergency repairs.
- **Low interest disaster loans** from the Small Business Administration or Farm Service Agency to cover uninsured property losses.
- **Individual and family grants** for serious disaster-related needs, available to those who are unable to repay a loan.
- **Other aid programs**, including crisis counseling, disaster-related unemployment assistance and legal aid.

Mitigation

Perhaps the most important element of emergency management, mitigation is the day-in, day-out effort to reduce disasters' long-term risk to people and property. FEMA's mitigation team works with government and professional groups and the public to reduce the effects of floods, earthquakes, hurricanes and other hazards. **FEMA helps** by:

- Promoting sound building design and construction practices.
- Providing grants for activities that reduce the impact of earthquakes, floods, hurricanes and other natural disasters.
- Educating the public on what to do through training programs, publications, and seminars.

FEMA helps move homes in floodplains to higher ground.

- Helping local communities adopt floodplain ordinances.
- Relocating homes and businesses away from high risk areas, and encouraging property owners to elevate buildings above flood level.
- Creating risk assessment maps to assist local planners with effective community planning.

Preparedness, Training and Exercises

Survival and quick recovery from disaster depend on pre-planning. **FEMA helps** the nation prepare for disaster by:

- Funding emergency planning in all 50 states and the U.S. territories.
- Helping states to design and equip emergency operations centers.

The Emergency Management Institute offers more than 300 separate training courses.

- Training emergency professionals and state and local officials at FEMA's Emergency Management Institute.
- Developing courses for state and local delivery and offering training by satellite through the Emergency Education Network (EENET).
- Sponsoring exercises that let people work together under conditions similar to a real disaster.
- Coordinating emergency plans and exercises for nuclear power plants through the radiological emergency preparedness program.
- Helping to minimize the risks posed by chemical stockpile emergencies and hazardous materials transport and storage.

Federal Insurance Administration (FIA)

The FIA administers the self-supporting National Flood Insurance Program, which offers federally backed flood insurance coverage to citizens in more than 18,000 participating communities.

FEMA helps flood victims recover by:

- Providing incentives to mitigate flood damage.
- Working in partnership with the insurance industry to sell and service flood insurance policies.
- Working with the nation's lending institutions to protect individual mortgages.

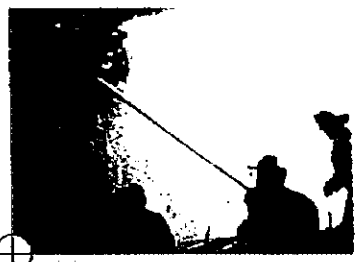
FIA's awareness campaign makes an important point: "We can't replace your memories, but we can help you build new ones."

- Increasing awareness about flood insurance benefits.
- Making flood insurance easier to buy.

United States Fire Administration (USFA)

In the U.S. each year, fire kills about 5,000 people and causes an estimated $9 billion in property damage. Through the USFA, **FEMA helps** reduce fire deaths and damage by:

- Developing new fire management technologies.
- Training the nation's firefighters and emergency medical professionals through the National Fire Academy.



Firefighters improve their management and response skills at the National Fire Academy.

- Educating the public on how to lower fire risk.
- Working with 32,000 fire departments to collect and analyze national fire statistics
- Honoring the memory of those who have lost their lives in the line of duty. There is a flame always burning at the National Fallen Firefighters Memorial in Emmitsburg, MD.

Crisis and Communication Technologies

In an emergency, with normal systems crippled, emergency teams must quickly set up operations, gather information, and maintain communications. **FEMA helps** by:

Geographic information systems aid decisionmaking.

- Bringing in mobile communications systems that open emergency lines when commercial phone systems are down.
- Through a special agreement with the Joint Chiefs of Staff, fielding an airborne disaster operations center — a communications-equipped 747 military jet — to allow immediate response following a catastrophe.
- Creating advanced computer models to predict the nature and extent of damage.

Many of the technologies FEMA uses also communicate in non-disaster situations:

- A World Wide Web site (www.fema.gov) provides news to the media, information on disaster assistance, a full library of materials, and global links for the emergency management community.
- The FEMA FAX line offers access to more than 1300 documents. You can receive an index of the documents available by calling (202) 646-FEMA.

Success Through Partnership

The success of America's emergency management system depends on partnership. At its center are FEMA and the many other federal, state and local government agencies who help America prepare for, respond to, recover from and mitigate the effects of disasters. Voluntary organizations and civic groups, along with private industry, also play an important role. But the partnership extends further. At its deepest level, it involves every American. Here are some ways **you can help:**

- Learn the risks that your community faces -- and what you should do if disaster occurs.
- Develop a family preparedness plan.
- Insure your property against flood.
- Take protective steps now — whether it's shoring up your house against flood or buying/making hurricane shutters. Don't wait till it's too late.
- In a disaster, watch out for those such as the elderly or the disabled who may need your help.

If you need more information, you can call your local emergency manager, or call your nearest FEMA regional office.

President Clinton and Federal Emergency Management Agency Director James Lee Witt are committed to strengthening FEMA's reputation as the very best emergency management system in the world.

"Every American needs to know that when their safety, their property or their livelihoods are threatened by disaster, that the full resources of this nation will be utilized to protect them and to help place them on the road to recovery."

- President Clinton

FEMA's Regional Offices

Region I:
Massachusetts, Connecticut, Maine, New Hampshire, Rhode Island, Vermont
J.W. McCormack Bldg.
Room 442
Boston, MA 02109-4595
617-223-9540 (p)
617-223-9519 (f)

Region II:
New York, New Jersey, Puerto Rico, Virgin Islands
26 Federal Plaza
Room 1337
New York, NY 10278-0002
212-225-7209 (p)
212-225-7281 (f)

Region III:
Pennsylvania, Maryland, Delaware, Virginia, Washington, DC, West Virginia
Liberty Square Building
2nd Floor
105 S. Seventh Street
Philadelphia, PA 19106-3316
215-931-5608 (p)
215-931-5714 (f)

Region IV:
Georgia, Alabama, Florida, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
1371 Peachtree Street, NE
Suite 700
Atlanta, GA 30309-3108
404-853-4200 (p)
404-853-4230 (f)

Region V:
Illinois, Indiana, Minnesota, Michigan, Ohio, Wisconsin
175 West Jackson
4th Floor
Chicago, IL 60604-2698
312-408-5501 (p)
312-408-5234 (f)

Region VI:
Texas, Arkansas, Louisiana, New Mexico, Oklahoma
Federal Regional Center
800 North Loop 288
Denton, TX 76201-3698
817-898-5399 (p)
817-898-5325 (f)

Region VII:
Missouri, Iowa, Kansas, Nebraska
911 Walnut Street,
Room 200
Kansas City, MO 64106
816-283-7054 (p)
816-283-7582 (f)

Region VIII:
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
Denver Federal Center
Building 710
Box 25267
Denver, CO 80225-0267
303-235-4813 (p)
303-235-4976 (f)

Region IX:
California, Arizona, Hawaii, Nevada, Pacific Island Trust Territories
Building 105
Presidio of San Francisco, CA
94129-1250
415-923-7100 (p)
415-923-7112 (f)

Region X:
Washington, Alaska, Idaho, Oregon
Federal Regional Center
130 228th Street, S.W.
Bothell, WA 98021-9796
206-487-4607 (p)
206-487-4622 (f)

The ICRC's role

Neutral Institution

In time of war, civil war or internal disturbances or tension, the ICRC acts as a specifically neutral intermediary between belligerents or adversaries and endeavours to ensure that the victims of such conflicts, whether civilian or military, receive protection and assistance.

Right of Initiative

The ICRC can take any humanitarian initiative consistent with its role as a specifically neutral and independent institution.

Guardian of the Principles

The ICRC monitors observance of the Movement's fundamental principles. It also decides on the recognition of National Societies, whereby they officially become part of the Movement.

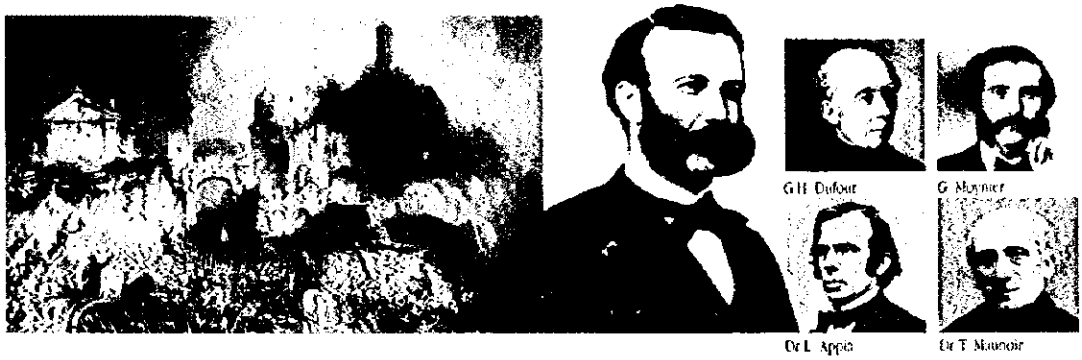
Promoter of the Geneva Conventions

The ICRC works to advance international humanitarian law and to explain and disseminate the Geneva Conventions. It carries out the duties incumbent upon it under these Conventions, ensures that they are applied and promotes their further development where necessary.

THE INTERNATIONAL COMMITTEE OF THE RED CROSS (ICRC)

At the origins of the ICRC

a battle ..... a man ..... a committee



History

It all began on 24 June 1859 in Solferino, a town in northern Italy, where French and Italian troops were engaged in a fierce battle against the occupying Austrian forces which was to leave 40,000 wounded and dead in only a few hours.

The medical services of the armies involved were quite inadequate to cope with the situation and the wounded were abandoned to their fate. The spectacle of their suffering appalled a visiting Swiss businessman named **Henry Dunant**, who set about helping them, regardless of their nationality, calling on the local population to join him.

On his return to Switzerland, Henry Dunant, unable to forget the horrors he had witnessed, related his experience of the ever-recurring tragedy of war in a book entitled **A Memory of Solferino**, which he completed in 1862. Dunant had the work printed at his own expense and sent copies to the reigning monarchs of Europe and to politicians, military officers, philanthropists and friends. It rapidly received unexpected acclaim among Europeans, who were largely unaware of the cruel realities of war and were shocked by the description.

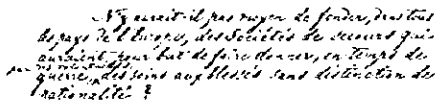
Gustave Moynier, a lawyer who was at the time President of the **Geneva Public Welfare Society**, was "deeply moved" by **A Memory of Solferino**. Anxious to act on the book's ideas, he immediately proposed that Dunant meet the other members of the Society to talk about his work. At the meeting a five-member Commission was set up, comprising, besides **Dunant** and **Moynier**, **General Guillaume-Henri Dufour**, **Dr. Louis Appia** and **Dr. Théodore Maunoir**, all Swiss citizens. The Commission, which met for the first time on 17 February 1863, adopted the name "**International Committee for Relief to the Wounded**".

During the ensuing months, the Committee's five members worked to organize an international conference which, in October 1863, brought together in Geneva the representatives of 16 States. The conference adopted a distinctive sign - **a red cross on a white ground** - to identify and thereby protect those who assisted wounded soldiers. It also marked the birth of the **RED CROSS** as an institution. Subsequently, the Committee took the title "**INTERNATIONAL COMMITTEE OF THE RED CROSS**" (ICRC).

Dunant the visionary

Dunant's merit lay in going beyond the spontaneous but isolated humanitarian gestures of his predecessors by proposing, in his book, ideas that were both innovative and practical and by promoting them with remarkable energy.

Would it not be possible, in time of peace and quiet, to form relief societies for the purpose of having care given to the wounded in wartime?



This idea led to the creation of the National Red Cross - and later Red Crescent - Societies.

Dunant also believed that the wounded should be protected and that those who assisted them on the battlefield should enjoy neutral status. He therefore proposed the establishment of

...some international principle, sanctioned by a Convention inviolate in character, which, once agreed upon and ratified, might constitute the basis for societies for the relief of the wounded in the different countries...

This second idea put forward by Dunant gave birth to the international humanitarian law, which first found tangible, written expression in the 1864 Geneva Convention.

The ICRC and the movement

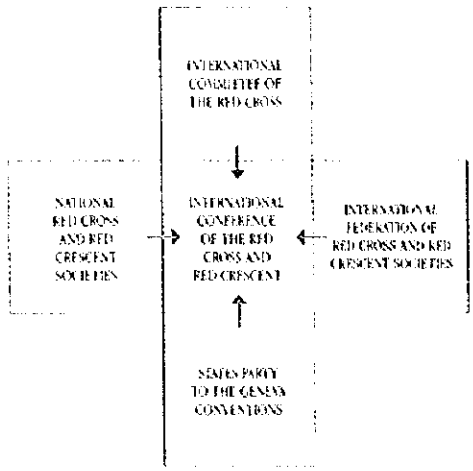
The ICRC is the founding institution of the International Red Cross and Red Crescent Movement, which now has the following components:

the International Committee of the Red Cross;

the International Federation of Red Cross and Red Crescent Societies (founded in 1919, this is the world federation of National Societies);

the National Red Cross and Red Crescent Societies, duly recognized by the ICRC; in October 1989, there were 149 Societies with more than 250 million members.

The three components normally meet every four years, together with representatives of the States party to the Geneva Conventions, at an International Conference of the Red Cross and Red Crescent. The role of the Conference, which is the Movement's highest deliberative assembly, is essentially to consider general problems, adopt resolutions and assign mandates.



Many eminent figures, following in the footsteps of the ICRC's founders, have carried forward the work that was begun in 1863, particularly through their writings (see box opposite).

Status, structure and financing of the ICRC

The ICRC is a private, independent institution, exclusively composed of Swiss nationals, with its headquarters in Geneva. It is neutral as regards politics, religion and ideology. Its international character derives from its mission, which is enshrined in the Geneva Conventions.

The ICRC's supreme body is a **Committee** whose members, not exceeding 25 in number, are all Swiss citizens appointed by co-option. The Committee meets in an **Assembly**, which sets general policies and guidelines.

The institution's field operations and administration are managed by its **headquarters** in Geneva and by **delegations** set up in areas of conflict throughout the world.

The ICRC is funded through voluntary contributions:

- from the States party to the Geneva Conventions;
- from the National Societies;
- from private donors;
- and through gifts and bequests.

The ICRC: guardian of the fundamental principles

Since the Movement's components work in a great variety of situations (different social and cultural contexts, conflicts, natural disasters), they require general guidelines to direct and give the necessary coherence to their efforts. In other words, the Movement needs a **unified doctrine**. In 1921, the Tenth International Conference of the Red Cross adopted a resolution recognizing the ICRC as "**the guardian and promotor of the institution's fundamental moral and legal principles...**"

However, it was not until 1965 that the Twentieth Conference, held in Vienna, gave the Movement its charter by establishing **SEVEN FUNDAMENTAL PRINCIPLES**, of which the ICRC was made the guardian.

HUMANITY
IMPARTIALITY
NEUTRALITY
INDEPENDENCE
VOLUNTARY SERVICE
UNITY
UNIVERSALITY

These principles are specific to the Movement and must be respected by all its components.

The ICRC issues and distributes in several languages a variety of publications on its activities worldwide, its ideals and the principles that guide those activities, and humanitarian law, among other subjects. They may be obtained from the National Red Cross and Red Crescent Societies or from the ICRC.

The ICRC: initiator and promoter of humanitarian law

Before 1863, humanitarian problems arising from armed conflicts were generally the object of *ad hoc* agreements among the belligerents. Such treaties (cartels) were therefore limited in time and space. Lacking more comprehensive legal protection, war victims fared poorly. The great merit of the ICRC's founders was to have perceived the need for **a single and enduring body of international law known to and applied by the States**.

To this end, they proposed to the representatives of ten governments, convened in 1863 in Geneva, a text which was to become the original Geneva Convention. Subsequently, the ICRC worked tirelessly to supplement this first legal instrument with other conventions and to have these adopted by an increasing number of States. The treaties currently in force are:

A. THE FOUR 1949 GENEVA CONVENTIONS

These Conventions demand respect for human beings in time of armed conflict and provide that persons not directly participating in the hostilities, such as the sick, the wounded, or prisoners, shall be protected, and that anyone in distress shall be helped and cared for without discrimination. Today, practically all States have ratified or acceded to the Conventions, on which the ICRC's work is based.

The Conventions afforded protection to the following:

First Convention: wounded and sick members of the armed forces, medical personnel, chaplains.

Second Convention: the wounded and sick, medical personnel and chaplains of armed forces at sea, the ships rocked.

Third Convention: prisoners of war.

Fourth Convention: civilians in enemy or occupied territory.

The States party to the Conventions pledge to:

- **care for** friends and enemies alike;
- **respect** every human being, his honour, family rights, religious convictions and the special rights of the child;
- **prohibit** inhuman or degrading treatment, the taking of hostages, mass extermination, torture, summary executions, deportations, pillage and the wanton destruction of private property;
- **authorize** ICRC delegates to visit prisoners of war and civilian internees, and to interview without witnesses persons in detention.

B. THE TWO 1977 ADDITIONAL PROTOCOLS

Because of new practices and the evolution of armed conflicts after 1949, it became evident that the four Conventions no longer provided sufficient legal protection for all victims, especially civilians. Those treaties therefore needed to be supplemented and extended by new texts. On 8 June 1977 a Diplomatic Conference convened in Geneva adopted two *Protocols Additional* to the four Conventions and applicable in the event of:

a) international armed conflict (Protocol I),

b) non-international armed conflict (Protocol II).

Public Information Division (19, avenue de la Paix, CH-1202 Geneva, Switzerland). These publications will provide readers with further information on various matters which, for lack of space, are merely touched on in this leaflet.

The ICRC's mandate

The protection afforded war victims by the 1864 Convention was rapidly seen to be inadequate, particularly by ICRC delegates working during the Franco-Prussian war of 1870. War brings not only physical but also mental suffering, such as that caused by the prolonged separation of prisoners of war from their families, yet the original Geneva Convention made no provision for problems of this type. The ICRC therefore took the initiative of opening an information bureau to forward news of prisoners to their relatives and give moral solace where needed. Another ICRC endeavour was to obtain the right to visit "political prisoners" from the Hungarian authorities in 1849.

The ICRC continued to take humanitarian initiatives, geared to the tragic effects of conflicts and their aftermath. It did not hesitate to act without a firm legal basis when necessary to increase protection for the victims of armed conflicts. Gradually, most of its initiatives were legalized, that is, incorporated into the new Geneva Conventions which it subsequently submitted to States for adoption.

This explains why the ICRC is mentioned several times in the 1949 Conventions and their 1977 Protocols. These treaties confer on it the **right to take action** (for example, to visit prisoners of war) and **the right to make proposals to States** (for example, to offer its services). The Movement's Statutes recognize that the ICRC has **a right of humanitarian initiative** in situations not covered by the Conventions or their Protocols.

All these rights constitute the permanent **MANDATE** conferred on the ICRC by the international community. It is this specific mandate which distinguishes it from other humanitarian organizations (see also "The ICRC's Rules").

Long before the Conventions conferred on the ICRC a special mandate to visit prisoners of war, its delegates had already inspected detention camps (here, in 1916, during the First World War).

The ICRC's work

The ICRC is active in the following conflict situations:

- **international armed conflicts**
- **non-international armed conflicts**
- **internal disturbances and tension**

The ICRC works to protect and assist victims in the following ways:

- its delegates **visit** persons deprived of liberty (prisoners of war, civilian internees, security detainees) in their places of detention (prisons, camps). They investigate only the **material and psychological conditions of detention**, since the ICRC never passes judgement on the reasons for detention. The delegates also interview without witnesses the detainees of their choice.

- The ICRC **brings assistance** to victims by providing medical care, setting up hospitals and rehabilitation centres. It also assists civilians by providing appropriate material aid as needed, such as food, shelter and clothing.

- The ICRC also runs a **Central Tracing Agency (CTA)**, whose main tasks are to:
  - trace persons whose families have no news of them or who have disappeared;
  - arrange for the exchange of family messages when normal channels of communication have broken down;
  - organize family reunifications and repatriations.

In all these situations, the ICRC strives to gain access to the victims, particularly those who have been deprived of their liberty. That is why discretion is essential to its humanitarian work.

Since the end of the Second World War, the ICRC has:

- **visited**, in many countries, civilian and military prisoners held in camps, prisons and hospitals because of armed conflicts or internal disturbances; for example, since 1945 the ICRC has visited, in situations not covered by the Geneva Conventions, over half a million "political detainees" in 95 countries; between 1980 and 1985 ICRC delegates carried out 12,250 visits to more than 600 different places of detention and registered or interviewed without witnesses 151,000 detainees in this category;

- reunited several hundred thousand families split up by war;

- provided **assistance** for war disabled in various parts of the world;

- **distributed** relief worth a total of 2 billion Swiss francs to conflict victims; among its largest relief operations since 1945 have been those carried out in Angola, Cambodia, Cyprus, El Salvador, Ethiopia, Hungary, Lebanon, Iraq, Mozambique, Nicaragua, Nigeria, Sudan, Thailand, Viet Nam, Yemen, Somalia and ex-Yugoslavia;

- **undertaken** a number of studies, in consultation with experts brought together at several conferences, with a view to developing international humanitarian law.

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EMERGENCY RESPONSE UNITS

- Health
  - Referral Hospital ERU
  - Basic Health Care ERU
- Water
  - Mass Water ERU
  - Specialised Water ERU
- Sanitation
  - Mass Sanitation ERU
  - Medical Sanitation ERU
- Telecommunication
  - Telecommunications ERU
- Logistics
  - Airport Logistics ERU
- Media
  - Information ERU

BASIC HEALTH CARE ERU (1)

- To start up basic health care services within 48 hours
- Provide basic curative/preventive and community health care in emergency situations
- provide core functions of the Primary Health Care concept
- Referrals to district health care referral hospital
- Services to be provided/adapted to district health care level

BASIC HEALTH CARE ERU (2)

- Catchment pop : approx. 20 000
- OPD ; use of WHO standard drugs / standard treatment protocols
- 10-20 overnight beds (service diarrheal/ARI cases)
- Deliveries
- Preventive services, mainly MCH components
- Health education and community based health care activities, training of local staff
- Disease & nutritional surveillance and reporting

BASIC HEALTH CARE ERU (3)

- Self contained minimum for one month
- 2 WHO New Emergency Health Kits (NEHK:s)
- Transport
- Shelter (tents) for clinic, health posts and staff
- Power
- Telecom
- Water
- Admin/Equipment
- 4 staff for one month
- Money, food

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RELIEF HEALTH SERVICE

Standardisation / ERU:s

- ERU 10 deployments
- Guidelines for Drug Donations
- Standard Relief Items/Health
- Guidelines for Handling Restricted Drugs
- WHO New Emergency Health Kit
- Minimal Performance Standards
- Regional Medical Supply System
- WHO Essential Drugs (MISP/NEHK)

CURRENT STRATEGIES AND PERSPECTIVES

Three priority areas for research & development

- Health response in complex emergencies
- Global food crisis
- Re-emergence of infectious diseases

RELIEF HEALTH SERVICE
EMERGENCY REPSONSE UNIT (ERU)

DISTRICT HEALTH

SPEC
WATER

MASS
WATER

REFERRAL
HOSPITAL
ERU

BHC
ERU

LOGISTICS ERU
TELECOM ERU

RELIEF HEALTH SERVICE

1995 MAJOR ACTIVITIES

GENERAL TOPICS

- WATER AND SANITATION
- FOOD AND NUTRITION
- EMERGING & RE-EMERGING DISEASES
- POPULATION MOVEMENTS
- REPRODUCTIVE HEALTH
- STANDARDISATION / EMERGENCY RESPONSE UNIT (ERU)
- CLINICAL CARE
- TECHNOLOGICAL DISASTERS
- PSYCHOLOGICAL SUPPORT/STRESS

RELIEF HEALTH SERVICE

SPECIFIC CHALLENGES

" A "

- Conflict Zones/Gray
- No Government (Somalia)
- MEGA Camp (Ngara/Goma)
- Hyper Mobile Refugees

INITIAL ASSESSMENT

- ✓ **Process by which are defined:**
  - ► **Priority needs and**
  - ► **Available resources**
  - ► **Set of objectives**
  - ► **Realistic plan of actions**
  - ► **In view of effective operations**

- ✓ Based on collection of data and information gathering

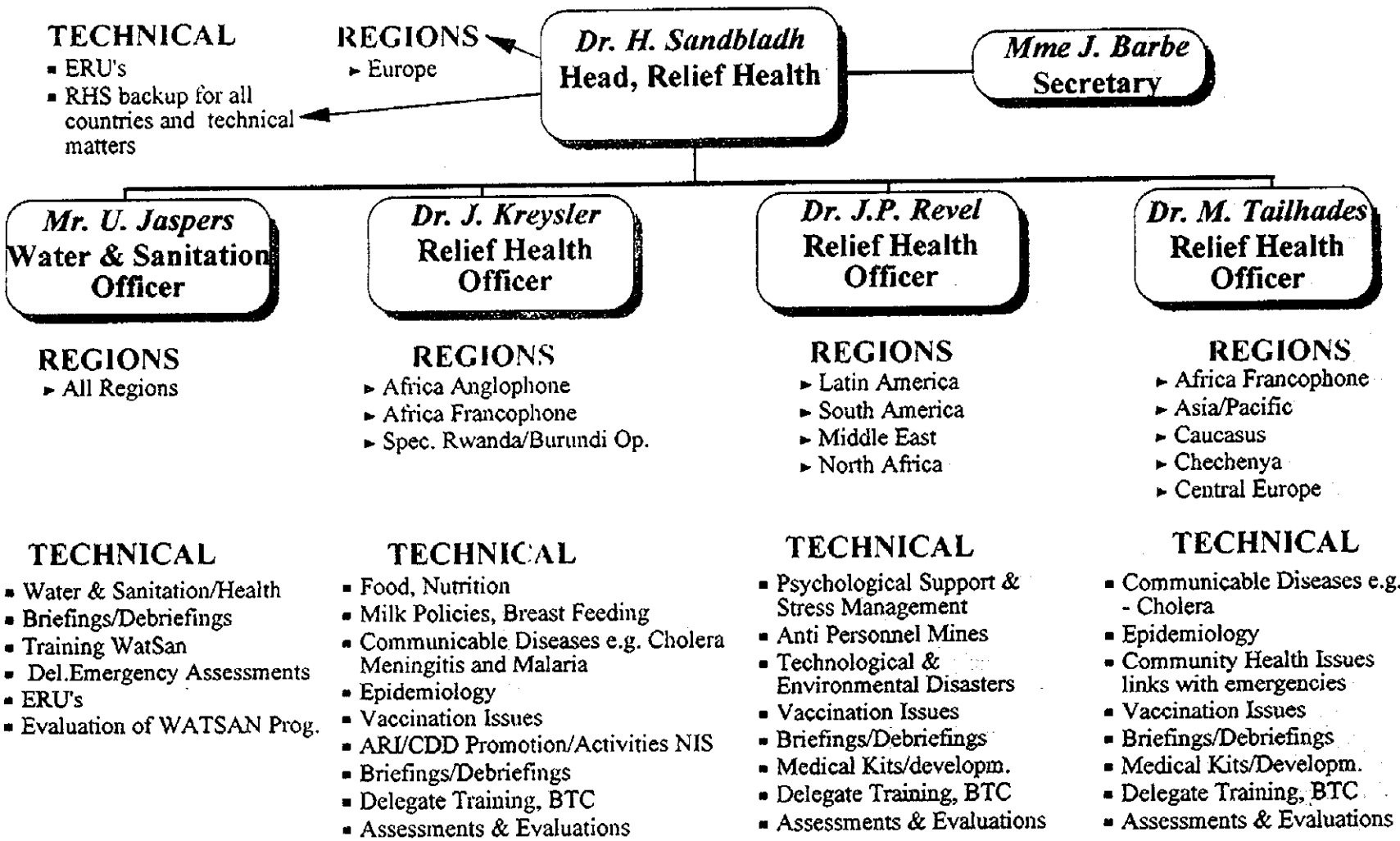
- ✓ Requires a thorough analysis and adequate decision making tools

BASIC NEEDS IN DISASTERS

- ✓ ESSENTIAL NEEDS
  - ► Water & Sanitation
  - ► Food
  - ► Shelters
- ✓ If unmet, they result in severe health problems

- ✓ THEN:
  - ► Medical care
  - ► Communication

RELIEF HEALTH SERVICE



September 1995

Referral Hospital

- Purpose
  - To serve as first level referral medical unit when local medical facilities are insufficient or have been destroyed
- Capacity
  - Population Served 150'000
  - 150 beds.
- Services
  - Simple Surgery
  - Internal Medicine
  - Obstetrics & Gynaecology
  - Paediatrics
  - Out Patients Dept (Triage, Registration)
  - Infectious Diseases.
  - Dental Extraction
- Comprises
  - Possible Therapeutic Feeding
  - Simple Laboratory
  - Pharmacy
  - Water
  - Sanitation
  - Electrical Po
  - Vehicles
  - Hospital Tents
  - Telecom equip.
- Personnel
  - 4 medical Officers
    - Surgeon
    - Anaesthetist
    - Paediatrician
    - GP
  - 7 nurses
    - 1 head nurse
    - 2 ward nurses
    - 2 operating theatre
    - 1 midwife
    - 1 Mother Child Health (MCH)
  - 1 pharmacist
  - 1 - 2 Technician
  - 1 lab technician
  - 60 local staff

Policy

FOOD AND NUTRITION

Introduction:

In carrying out their humanitarian mandate to assist the most vulnerable in time of emergency or within on-going service programmes, the International Federation of Red Cross and Red Crescent Societies and individual National Red Cross and Red Crescent Societies are heavily involved in the provision of food aid and nutritional support.

Scope:

This policy addresses specific responsibilities within emergency response operations and for the implementation of long-term health and nutrition programmes, and also with respect to advocacy on food aid and nutrition issues.

National Society and International Federation programming and advocacy aims to incorporate nutrition objectives into general health and development programmes and guidelines as well as in emergency response operations, and in this way improve the quality of diet and the general health condition of programme beneficiaries. ***This policy refers to Red Cross initiatives related to food and nutrition which are not directly related to food aid.***

Statement:

The International Federation and each individual National Society shall:

1. Seek to provide food aid which is culturally acceptable, nutritionally wholesome and free from undesirable long-term adverse consequences. In the case of food donations which cannot meet these criteria, they may be declined.

2. Request food aid donors to provide adequate funding to meet necessary transportation, storage and distribution costs of food aid.

3. Purchase food *(either for general ration or supplementary purposes)* in a manner which promotes the economic development of the least developed countries and the most vulnerable people in these countries.

4. Make use of food as a general household economic input beyond the acute malnutrition stage, in order to strengthen the security of the most vulnerable, and assist the beneficiaries to gain access to development opportunities such as attendance at schools and training courses.

5. Ensure that the undertaking of *(supplementary and therapeutic)* feeding activities, including preventing and/or treating micronutrient deficiencies, primarily Vitamin A, iron and iodine deficiencies, are considered as important. ***This is prominent when there is,*** *(especially when there is)* no specialised agency willing to undertake the necessary extra feeding programmes, and that they are targeted to the most vulnerable.

6. Support the policy concerning safe and appropriate infant and child feeding, and the correct use of complementary foods. ***Promote and protect breast-feeding,*** discourage the distribution of breast-milk substitutes. When such substitutes are absolutely necessary, they may be accepted if they are provided together with clear instruction for safe mixing, and for feeding with cup and spoon.

7. Accept, *(supply and distribute)* dried skim (DSM) only if it has been fortified with vitamin A and is supplied in a dry form. ***DSM should not be distributed as part of food rations unless its correct and hygienie usage can be assured.*** Liquid or semi-liquid products, including evaporated or condensed milk are not acceptable.

8. Promote the inclusion of women in all nutritional programmes, particularly as regards their involvement in the decision-making processes of these programmes, and give priority to the development and promotion of nutrition programmes targeted at children, pre-adolescent and adolescent females.

9. Organise and participate in both emergency and long-term national, regional and local programmes to promote nutrition and food safety education, appropriate diets, healthy life styles and breast-feeding.

10. Ensure that all food and nutrition programmes have competent surveillance and that the results of such surveillance are available in a timely manner.

Responsibilities:

National Societies and the International Federation have a responsibility to ensure that all food and nutritional programming is in compliance with this policy; that all staff and volunteers participating in such programmes are aware of the rationale and details of this policy; and that all relevant governmental, intergovernmental and non-governmental partners are adequately informed of this policy.

National Societies have the responsibility to identify their role in an overall country strategy with regard to food and nutrition programmes

Reference:

This policy was adopted by the xth Session of the General Assembly of the International Federation of Red Cross and Red Crescent Societies on x.x.97. The policy replaces all previously established food and nutrition policies.

Further reference texts are: Emergency Response Policy, Development Policy, Guidelines on this & that .....

Policy

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10. Ensure that all food and nutrition programmes have competent surveillance and that the results of such surveillance are available in a timely manner.

HEALTH

The International Federation and each individual National Society shall:

1. Strive to be the voice of social conscience in protecting the health of the most vulnerable populations.

2. As auxiliaries to the governments, advocate the creation, maintenance and continuous development and improvement of a national health care system which is capable of meeting the essential health needs of all of the population, in particular the most vulnerable.

3. Within the context of the national health needs identify the appropriate areas for the Red Cross and Red Crescent intervention to meet the true needs of the most vulnerable and provide the corresponding health care services to the extent possible.

4. In providing health care services give priority to Integrated Community Based Health Programmes, thus ensuring maximum benefit to the beneficiaries of these services.

5. Ensure that the Integrated Community Based Health Programmes shall include and encompass, to the extent possible, all components of Primary Health Care so that the essential health needs of the most vulnerable are provided for.

6. Ensure that in providing health care services special attention is accorded to the current and future trends as they affect the health of the most vulnerable populations. In particular, the necessary emphasis will be given to prevention, control and treatment of infectious diseases, including the emerging and re-emerging diseases.

7. Ensure that the health care services thus provided will give priority to meeting the special needs of children and women, with emphasis on adolescent girls, particularly incorporating considerations of sexual and reproductive health, as well as the elderly, the poor, the neglected and the marginalised.

8. See to it that the relevant components of health care are incorporated in and are an integral part of all their humanitarian work and programmes such as disaster preparedness.

9. Ensure that all health care services provided in emergencies shall take the long-term sustainability of services into consideration, with the assurance that services provided in any prolonged emergencies will develop into sustainable integrated community based health care.

10. Strive to ensure the availability of financial, material and high quality human resources for the provision of health care services as described above.

T:\EVERYONE\COMM&POL\PRINCIPL\HLTHPOL.SAM

(8) MDM

Médecins du Monde

世界の医療団

事務局

200名の専従スタッフの内、半数がパリ本部で、残りの半数が地方委員会及びフランス国内32の活動拠点で活動しています。事務局には以下の担当部署があります。

・ミッション担当
・登録ボランティアの管理
・ロジスティクス担当
・一般ボランティア担当
・ドナー担当
・経理
・人事
・広報
・情報処理担当
・国際関係担当

ミッション実施の計画と決定

MDMには組織全体の運営を担当する理事会や運営委員会の他に、アジア、アフリカ、アメリカ、ユーラシアなど世界各国の政治、社会保健衛生、人権の尊重の状況などを毎月分析してその国への介入の仕方をミッション委員会に提案する大陸別考察グループと、エイズ、バイオロジー、精神医学など各分野の専門家がそれぞれの専門知識、能力や経験を各ミッションの責任者に提供する目的で組織されたテーマ考察グループがあります。

各ミッションはミッション責任者（ボランティア医師）とプログラム責任者（MDMの専従スタッフ）によって運営されますが、大陸別考察グループの代表、理事会メンバー及び各ミッションの運営責任者が集まってそれぞれのについての討論、考察、提案を行うミッション委員会が週一回MDM本部で開かれ、運営をサポートしています。ミッション委員会は公開されており、現地から戻ってきた専門家やボランティア、更に一般の人々の参加も受け入れています。

大陸別考察グループやテーマ別考察グループで提起されたプログラムは、ミッション委員会で協議され運営委員会で実施が決定されます。ミッション実施が決まると、登録ボランティアの中からその分野で経験のある医師やロジスティクス専門家を選び、現地に予備ミッションを送ります。彼らは細かい基準に従って調べあげた内容に基づき、現地での人的ニーズ（必要な医師、看護婦などの数）と設備面でのニーズ（必要な医療器材や医薬品）を特定します。また同時にこれらの人や物資を現地にどのように運ぶかも決めます。

この予備ミッションの帰国を待って運営委員会が開かれ、そこで現地の状況が説明され、ミッション派遣の最終判断が下されます。

財政

MDMは財政的透明性と厳正という基本姿勢を共有するNGOの集まりであるCOMITE DE LA CHARTEに加盟しています。MDMの会計はドナーに公開され、毎年外部の独立した会計監査が行われます。

収入

いかなる条件もつけずにすべての人々を助けるためには、MDM自身、何のしがらみも無く自らの意志、イニシアチブで活動しなければなりません。どこにも依存しない完全な財政的独立を保たねばならないのです。そのためにMDMでは資金全体における民間からの寄付金（個人の寄付、企業のメセナなど）の割合を５５％以上に保ち、対して国連やEUなど公的機関からの助成金は４５％以下と厳しく制限しています。

1996年度の年間予算は2億3千万フラン（約50億円）でした。

支出

1995 年度の総支出は２億５千万フランで、その内訳は事業費（救援活動そのものに使われた金額）が 65.2%、募金経費（DM 作成・郵送）が 16.2%、広報経費（ニュースレター印刷、キャンペーンなど）が 5.8%、そして残りの 12.7%を事業管理費が占めました。 MDM は 1995 年１年間に世界 53 ヶ国に救援チームを派遣しましたが、海外事業費の 42.4%が緊急援助に、56%が長期開発プロジェクトに当てられました。

ドナー委員会

MDM の活動はそれに賛同する 87 万人のドナーから送られてくる寄付金によって支えられています。この資金の独立性は保証され、ドナーに対して会計報告を行う義務を負っています。1990 年、MDM はドナー委員会を発足しました。同様の機関を有するのは NGO では MDM が唯一無二です。ドナーは年に一度総会を開き、３年任期の委員長を選出します。更に委員長はドナーの中から 12 名を選びドナー委員会を結成します。

ドナー委員会は毎月招集され、場合によっては MDM のミッションの行われている現地へ赴き、その有益性の評価を行うこともあります。MDM の運営部門は同委員会に絶えず予算と資金の使い方についての情報を提供しています。

1996 年 12 月、MDM は、フランス国家会計監査役協会が毎年、財務管理に関する情報を一番良く、明確に一般公開したフランスの上場企業、非上場企業、自治体、NGO、財団に対して与える『クリスタル賞（グランプリ）』を受賞しました。

ミッション例

緊急ミッション

アフガニスタン（ヘラート）	医療、医療教育、政治的理由による国外亡命者・帰還者のキャンプ
アフガニスタン（カブール）	医療援助、小児科
アンゴラ（ベングーラ）	内科・外科医療、小児科教育
アンゴラ（Negage）	外科支援、治療、教育
ボスニア（ゼニツァ、サラエボ、ツズラ、ゴラジュデ）	物資供給、医療援助、青少年のための心理的外傷治療センター設置
ブルンジ（ブジュンブラ、ガトゥンバ）	難民に対する医療、外科支援、医療教育
クロアチア（カザン、ベリカクラデュサ）	保健衛生面の援助
ルワンダ	難民キャンプ、孤児院
ハイチ（Grande Anse/Jeremie）	マラリア、衛生、小児科、物資供給、医療教育
リベリア（モンロビア）	聖ジョセフ病院の小児科
マリ	モール族及びトゥアレグ族に対する医療援助
北イラク（ラニア、アザディ）	外科支援、難民キャンプの医療援助、医療教育、予防接種
フィリピン(ケソン)	アンジェラ台風の犠牲者に対する緊急援助
南スーダン（マンキエン、モゴク）	栄養医学面での援助、プライマリーヘルスケア
チェチェン（グロズヌイ、ナズラン）	難民及び亡命者に対する援助
ザイール（ウビラ）	難民にたいする医療
日本（神戸）	地震の被災者援助

1987　エチオピア　　1989　ルーマニア　　1991　旧ユーゴ
1992　ソマリア　　1994　ルワンダ　　1995　日本、ボスニア、チェチェン
1996　レバノン、中国、リベリア、ザイール・ルワンダ

長期開発プログラム

様々な理由により飢餓、疫病、衛生設備の不備、医療教育の不足など基本的な衛生上の問題を抱えている国や地域の人々に対し、長期的に援助を行っていこうとするものです。派遣医療チームによる診察や治療はもとより、現地病院や診療所の建設や復旧、必須医薬品の配布、住民を対象とした保健・公衆衛生教育；現地医療スタッフの育成などを実施します。最終的には現地に基本的な衛生機構を確立し、住民が自立できることを目的としています。

この長期開発ミッションの枠内で、MDM が 1994 年 6 月より３年計画で実施しているミャンマーの HIV・エイズ予防プログラムでは、ミャンマーの厚生省の協力を得てミャンマー国内 110 箇所の医療機関で医療関係者とその他の教育者の教育を行い、MDM がこのプログラムのために特別に考案したエイズ予防キットの配布を実施しています。このプログラムは現地日本大使館から資金援助を受けています。

MDM はこれら現地での活動の他に、次の各制度によっても海外の恵まれない子供たちの援助を実施しています。

養子縁組制度

1988 年に設立された制度で、MDM は国際養子縁組委員会によってルーマニア、エクアドル、アルバニア、ブラジル、コロンビア、ボリビア及びベトナムで活動する権限を与えられています。1995 年度は 135 人の子供たちが新しい家族に引き取られました。

証言・提言

証言し、報告し、常に視線による干渉を行うことは MDM の基本理念の１つです。1993 年、旧ユーゴスラビアでの非人道的な犯罪に対して『民族浄化阻止』というテーマで告発キャンペーンを実施し、人権侵害に関する MDM 会議を開催しました。また、ボスニア、クロアチア及びセルビア難民から、民族浄化の実態を証明する 130 もの証言を集め、旧ユーゴスラビアでの犯罪を裁く国際司法裁判所に報告しました。

MDM の活動パートナー

1996 年度、MDMは国連高等難民弁務官事務所(UNHCR)、ユニセフ、ユネスコ、国連女性開発基金(UNIFEM)、国連開発計画(UNDP)、世界銀行、欧州連合(EU)、各国政府と協力して活動しました。

運営

毎年総会が開かれ、3000 人の会員（ボランティア）の投票によって理事会のメンバーが選出されます。理事会のメンバーの入れ替えは毎年３分の１ずつ行われます。理事会は 14 名のボランティア医師及び看護婦から成り、毎月会合を開いて重要な方針や基本的な決定を行います。また、常設機構の責任者（事務局長）の任命も行います

新しいミッションの開設や現在動いているミッションのフォロー、組織の運営・財政面の管理に関する審査を行うのは理事会執行部と事務局の各担当部長から構成される運営委員会で、週に一度開かれます。この他、地方委員会の代表と理事会から成る諮問委員会は年に３回集まり、フランス国内外での活動の発展について考察を行います。

MEDECINS DU MONDE
世界の医療団

世界の医療団はフランス語での正式名称をMEDECINS DU MONDE (メドゥサン・デュ・モンド、略称 MDM)といいます。“メドゥサン”は『医師』、“デュ・モンド”は『世界の』という意味です。国籍、民族、宗教を越えて緊急援助が必要な国々に医師や看護婦を派遣するボランティアによる民間医療援助団体 (NGO)です。1980年3月7日、ベルナール・クシュネル医師を中心とした友人グループがイル・ド・リュミエール(『光の島』の意)号をチャーターして南シナ海をさまようベトナムのボートピープルを救助したことから始まった活動は17年を経た現在では、年間36の緊急ミッションと116の長期開発ミッションを世界53ヶ国に派遣するようになりました(1995年度実績)。MDMは国連経済社会理事会及びその下部機関の公式会合へのオブザーバーとしての出席、議題の提案、発言などの資格を得ています。

機構

今日MDMは約3000人の医療・専門ボランティアに支えられ、年間150余りの海外ミッションと31のフランス国内拠点を運営しており、常に400人以上の専門家が現地で援助活動を行っています。加えてMDMの事務局では約200名の専従スタッフが活動・運営の基盤を支えています。

また、海外には7つの代表団(スペイン、アメリカ、ギリシャ、イタリア、キプロス、スイス、スウェーデン)と4つの事務局(日本、カナダ、ベルギー、オランダ)が、フランス国内には15の地方委員会があります。地方委員会はパリ本部の決定に沿いながらそれぞれ独自の活動も行っています。

1996年12月、MDMインターナショナルは国連経済社会理事会(ECOSOC)の一般協議資格(General Consultative Status)を取得しました。これにより、MDMはECOSOC及びその下部機関のすべての会議の仮議題の通知を受ける、これらの会議へのオブザーバーとしての出席、意見書の提出、会議での公式発言、議題の提案などの権利を与えられています。

活動

MDMは『助ける、治療する、証言する』という基本理念をもとに様々な活動を行っています。援助の対象として、その被害の原因(武力闘争、人災、自然災害など)は問いません。MDMの活動をおおまかに分けると次のようになります。

緊急派遣プログラム

地震や洪水などの自然災害に突然襲われ為すすべのない被災者や、紛争の勃発により危険な状態に置かれた人々を一人でも多く救うために、事件・事故発生後できるだけ72時間以内に現地に救援隊を派遣します。登録されている3000名の医療ボランティアは基本的にいつでも出発する用意ができており、基本の医療器具一式も常時用意されています。

1995年1月17日の阪神大震災の際も、医師3名、看護婦2名及びロジスティクス専門家1名から成る医療チームがパリから派遣され、長田区役所を拠点に被災者の支援にあたりました。

《設立以来の緊急派遣例》
1980　ベトナムのボートピープル　　1981　アフガニスタン　　1983　レバノン

長期ミッション

アフガニスタン（ヘラート）	Djeratu 病院における産婦人科援助
アフガニスタン（ファラ、ワルダック）	病院支援
南アフリカ（ボッツァベロ）	プライマリーヘルスケアに関する技術移転
ベナン	仮診療所の支援
ミャンマー	エイズ・麻薬中毒予防プログラム（６ヶ所）
ミャンマー（ヤンゴン、モールメイン）	麻酔科教育
ブラジル（ボアヴィスタ）	ヤノマミ族に対するプライマリーヘルスケア
カンボジア（カルメット）	カルメット病院支援、貧窮者に対する援助
カンボジア（プノンペン）	刑務所内での医療、教育、エイズ患者に対する医療
カンボジア（モンドルキリ）	プライマリーヘルスケア、医薬品の供給
カンボジア（シアヌークビル）	教育、プライマリーヘルスケア
中央アフリカ（バンギ）	検診/エイズ予防
コロンビア	アパポリインディアンに対する医療
コロンビア（ボゴタ）	ストリートチルドレンに対する医療
コートジボワール	エイズ
エチオピア（アジスアベバ）	外科援助、リハビリ
エチオピア（Mehal-Meda/ノールショア）	リハビリセンター、教育、医療器材及び医薬品供給
エチオピア（ノールショア，アファー）	診療所の開発
ガテマラ（Ixican 地方）	コミュニティーの保健衛生機構への支援
ギニア（キンディア）	病院の復旧、エイズ対策
ハイチ（ピラート）	外科支援
ハイチ（Micivih）	抑圧の犠牲者に対する精神医学面での支援
ラオス（Outhoumphone. Savannaketh）	プライマリーヘルスケア、外科医教育
マダガスカル（マナラ、Moroantsetra）	プライマリーヘルスケア、家族計画
マダガスカル（アンタナナリボ）	エイズ予防及びエイズ教育
マリ（モプチ）	産科外科（膣瘻）
モザンビーク（マピュト）	エイズ対策、ストリートチルドレン
ネパール	公衆衛生、結核対策、母子の健康
ニカラグア（シウナ）	プライマリーヘルスケア
ニジェール（アガデ）	地域健康員の育成
ニジェール（ビリ，タバラク）	教育、トゥアレグ族に対する医療支援
ウガンダ（カクート、カンパラ）	医療援助、エイズ
ペルー（イキトス）	結核、マラリア対策、教育
ポーランド（ワルシャワ）	虐待されている子供の救済
中央アフリカ共和国（バンギ）	エイズ：検診と教育
ルーマニア（ブカレスト）	子供と家族基金、子供の境遇を監視
ルーマニア（ヤーシ,オクランド）	教育、エイズ
ロシア（サントペテルスブルグ）	ストリートチルドレンの救済、麻薬中毒患者のリハビリ
ロシア（モスクワ）	高齢者に対する医療援助、健康と地勢学面の情報収集
ルワンダ（チャンググ、ビュンバ）	心理医学プロジェクト、身寄りのない子供の世話
ルワンダ（ロビーング）	ルワンダに関して国際裁判所への支援
ルワンダ（Mibilize. Nyiamirambo）	孤児院の復旧
ナイジェリア	トゥアレグ族に対する医療援助
西サハラ(Tinfouf)	医療教育、医薬品供給

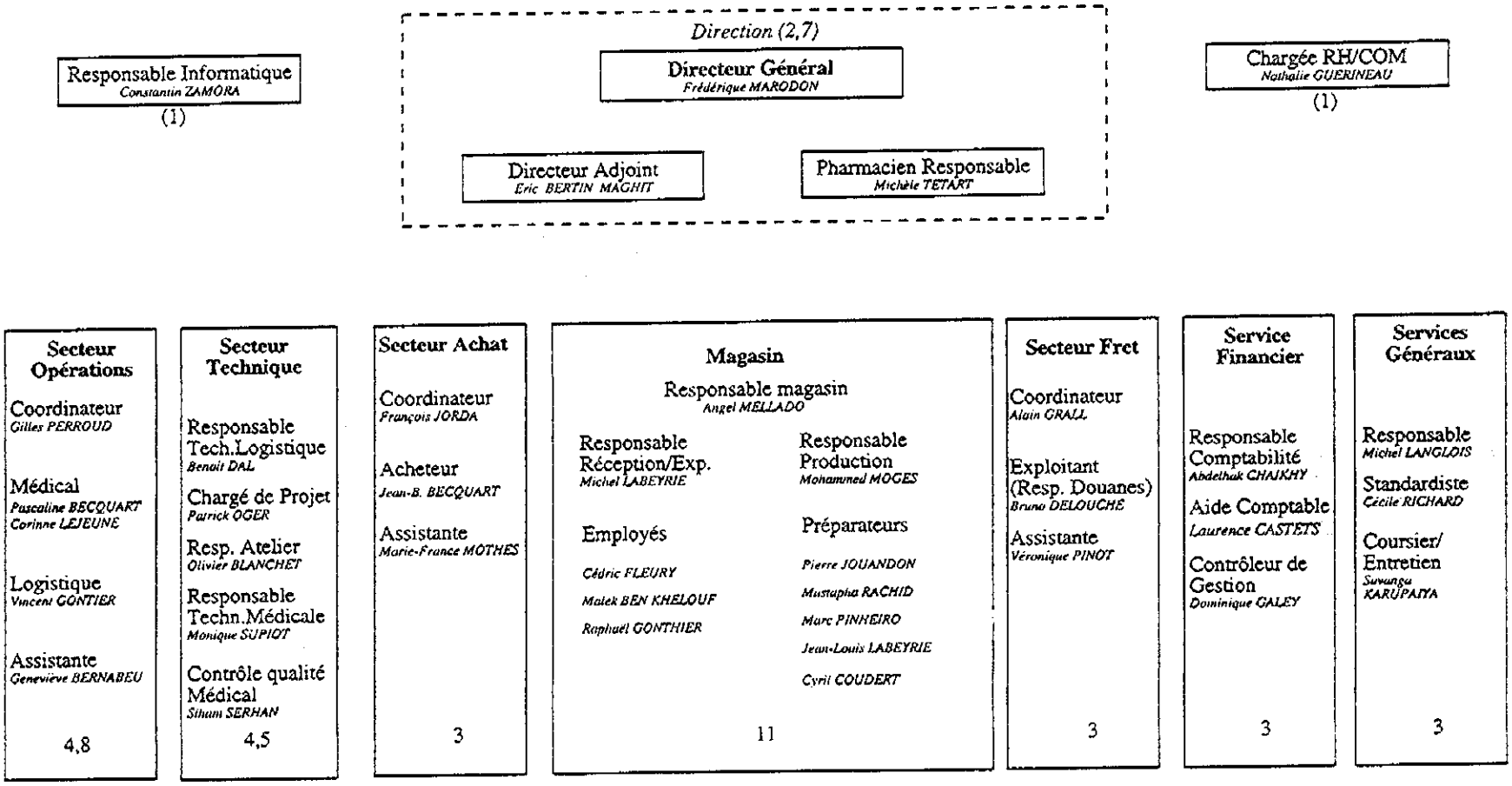
シベリア（Lamal、Anadyr）	プライマリーヘルスケアに関する技術教育、ラジオネットワーク設置、医学学校への支援、アルコール中毒対策
タンザニア（ブコバ）	社会保健衛生援助、エイズ、孤児
バヌアツ（Pentecôte 島）	プライマリーヘルスケア
ベトナム（ホーチミン市、ハノイ）	無料診療所のオープン
ベトナム（サイゴン、ハノイ、ダナン）	産婦人科、
ベトナム（ソックトラン）	教育者の教育、女性に対する保健衛生教育
ベトナム（ホーチミン市）	コンドーム・カフェ
ザイール（N'gandajika）	保健衛生機構の復旧、医療スタッフの教育、エイズ

パリ本部
住所： 62 rue Marcadet, 75018 Paris FRANCE
電話： (33)(1)44.92.15.15.
FAX： (33)(1)44.92.99.92
理事長：Jacky MAMOU (小児科医)
事務局窓口：Philippe LEVEQUE（開発部長）

日本事務局
住所：〒106 東京都港区東麻布 1-23-5
PMC ビル 6F
電話：(03)3585-6436　FAX：(03)3585-1134
代表：Gael AUSTIN (ガエル・オスタン)
スタッフ：荒井康子

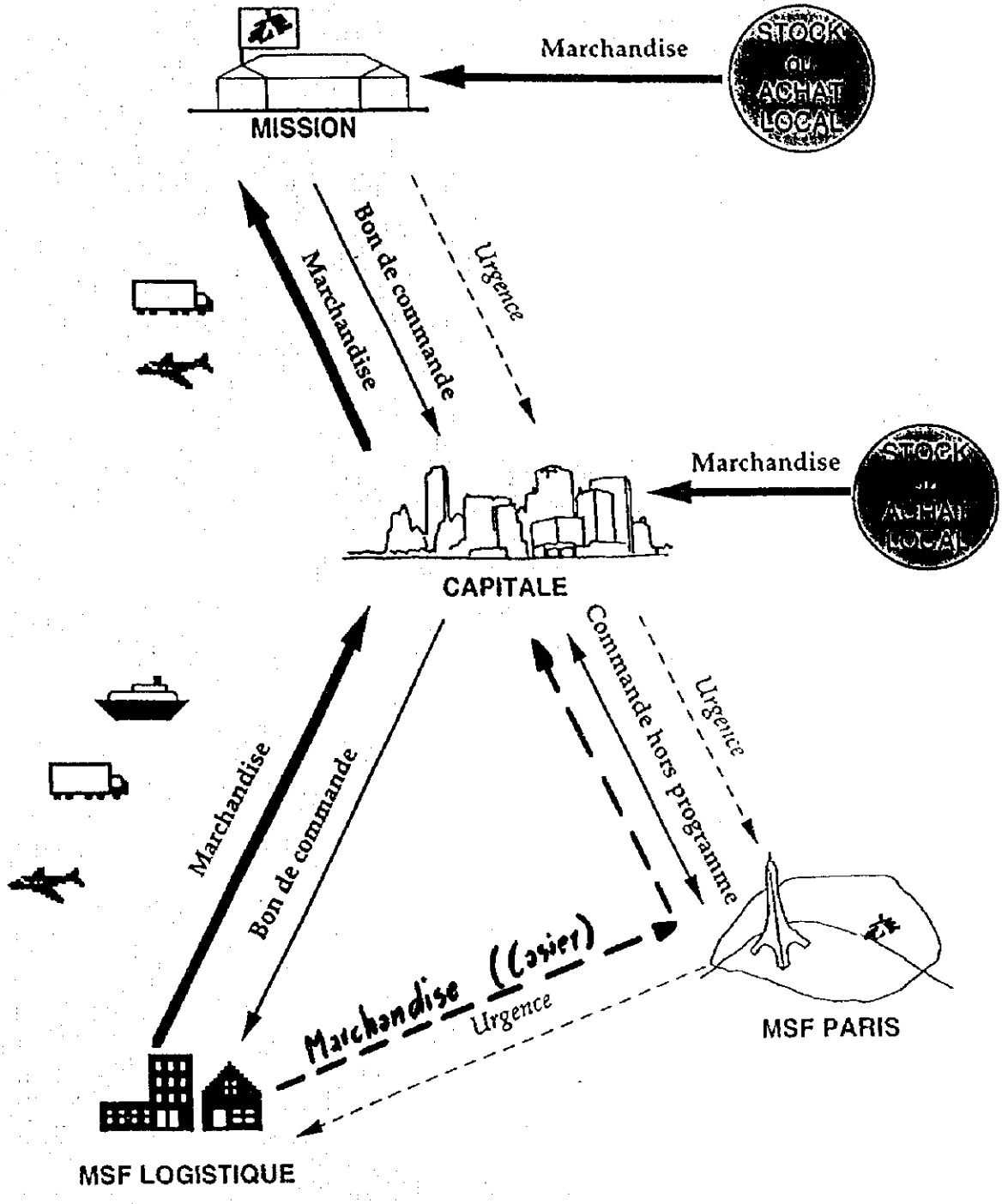
(9) MSF組織図

ORGANIGRAMME MSF LOGISTIQUE - *septembre 97*



TOTAL POSTES : 37 temps plein
TOTAL SALARIES : 39

Circuit d'approvisionnement



NG/23/09/97

ORGANIGRAMME MSF LOGISTIQUE - *septembre 97*

Responsable Informatique
Constantin ZAMORA
(1)

Direction (2,7)

Directeur Général
Frédérique MARODON

Directeur Adjoint
Eric BERTIN MASHI

Pharmacien Responsable
Michèle TETART

Chargée RH/COM
Nathalie GUERINEAU
(1)

Secteur Opérations

Coordinateur
Gilles PERROUD

Médical
Pascaline BECQUART
Corinne LEJEUNE

Logistique
Vincent GONTIER

Assistante
Geneviève BERNARD

4,8

Secteur Technique

Responsable Tech.Logistique
Benoit DAL

Chargé de Projet
Patrick OGEN

Resp. Atelier
Olivier BLANCHET

Responsable Techn.Médicale
Monique SUPIOT

Contrôle qualité Médical
Silvain SERMAN

4,5

Secteur Achat

Coordinateur
François JORDA

Acheteur
Jean B. BECQUART

Assistante
Marie-France MOTHES

3

Magasin

Responsable magasin
Axel METJADO

Responsable Réception/Exp.
Michel LABEYRIE

Employés
Cédric FLEURY
Malek BEN KHELOUF
Raphael GONTHIER

Responsable Production
Mohammed MOGES

Préparateurs
Pierre JOUANDON
Mustapha KACHID
Marc PINHEIRO
Jean-Louis LABEYRIE
Cyril COUDERT

11

Secteur Fret

Coordinateur
Alain GRALL

Exploitant (Resp. Douanes)
Bruno DELOUCHE

Assistante
Veronique PINOT

3

Service Financier

Responsable Comptabilité
Abdellah CHAIKHY

Aide Comptable
Laurence CASTETS

Contrôleur de Gestion
Dominique GALEY

3

Services Généraux

Responsable
Michel LANGLOIS

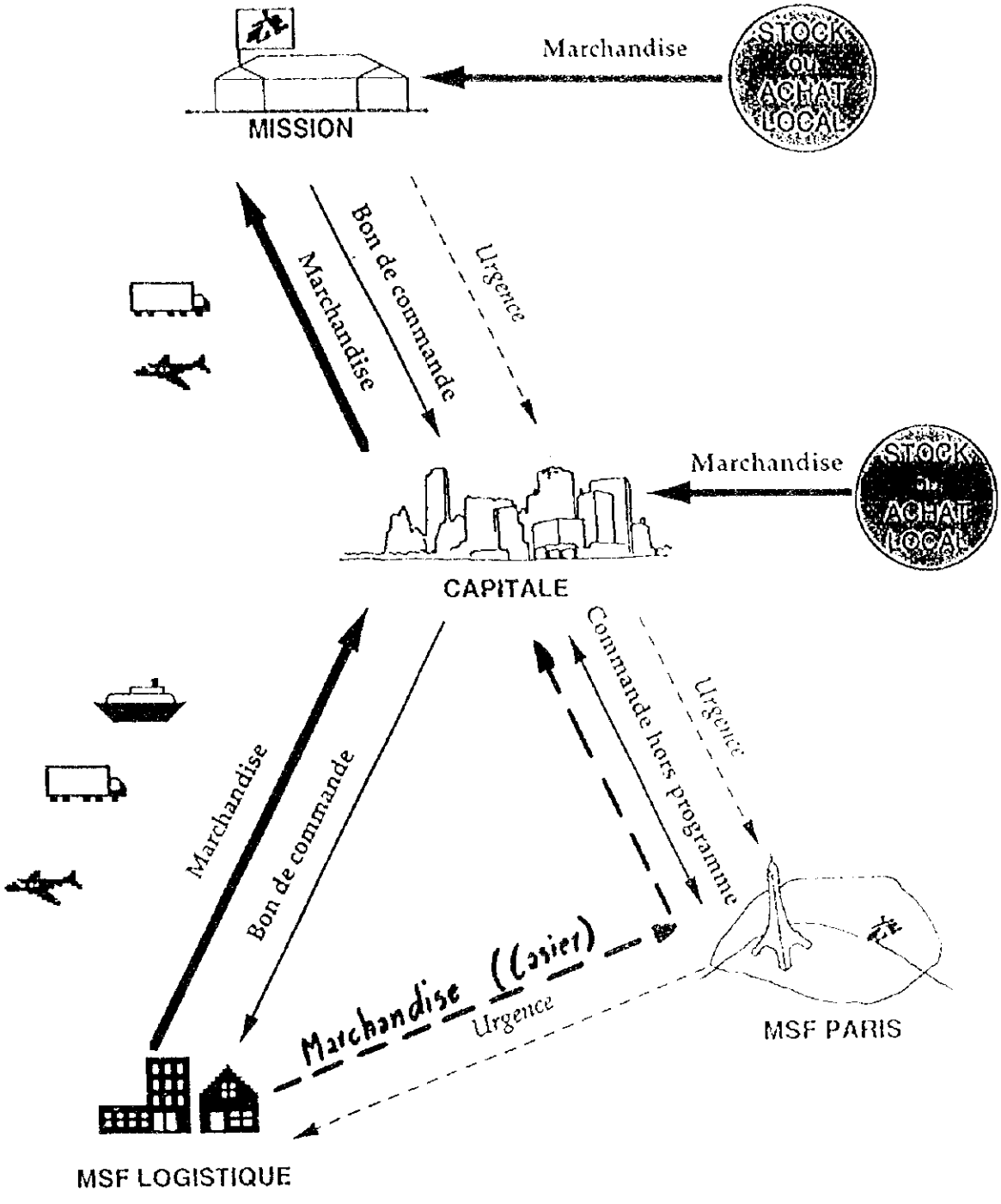
Standardiste
Cecile RICHARD

Coursier/ Entretien
Suvanya KARUPAIYA

3

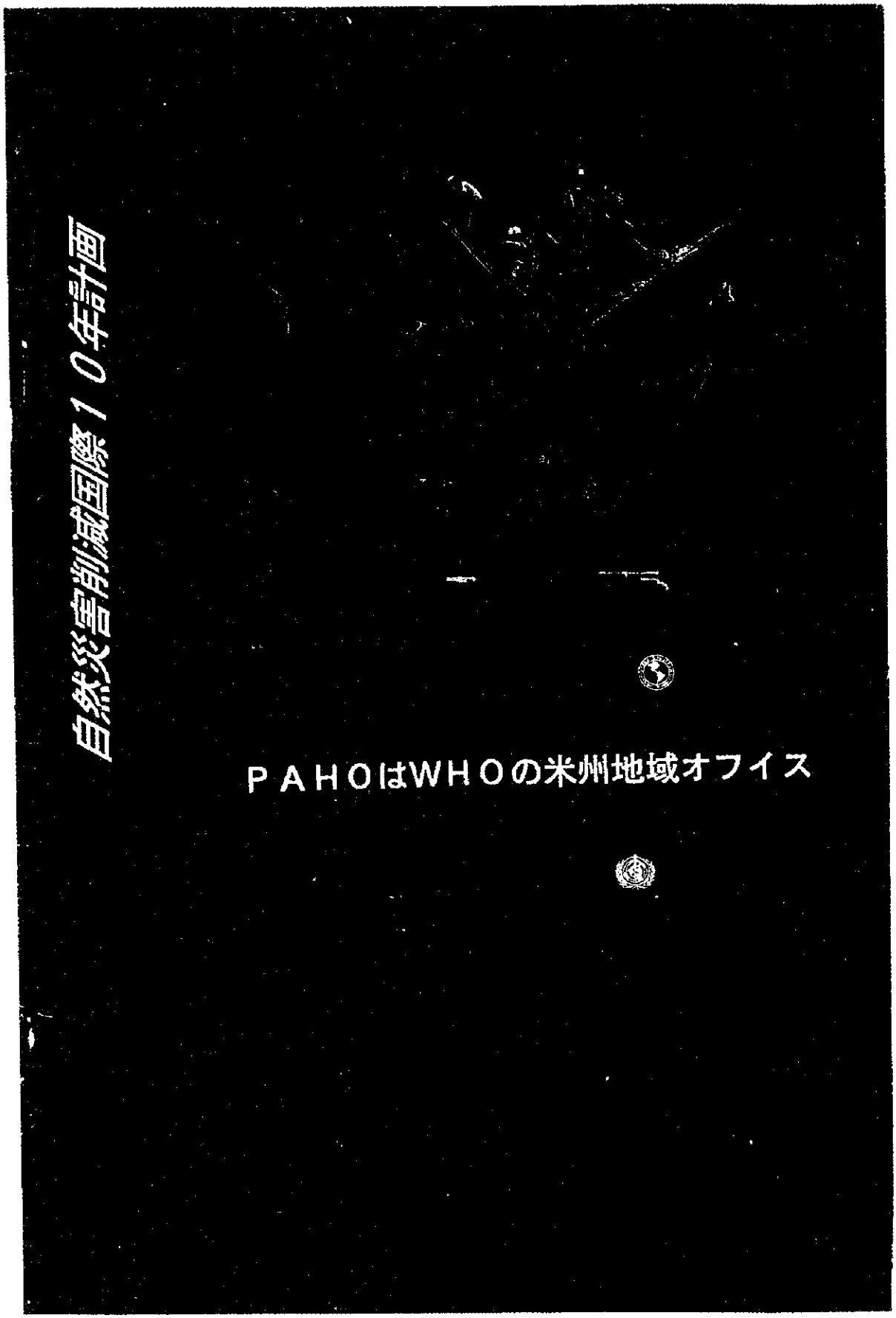
TOTAL POSTES : 37 temps plein
TOTAL SALARIES : 39

Circuit d'approvisionnement

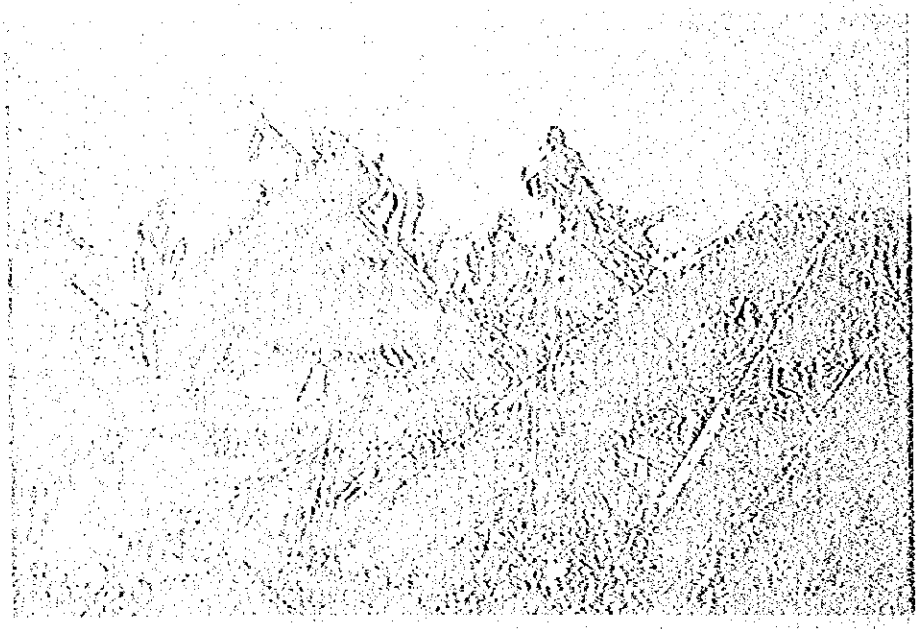


NG/23/03/97

(10) PAHO



災害対応・防止
救済プログラム



PAHO

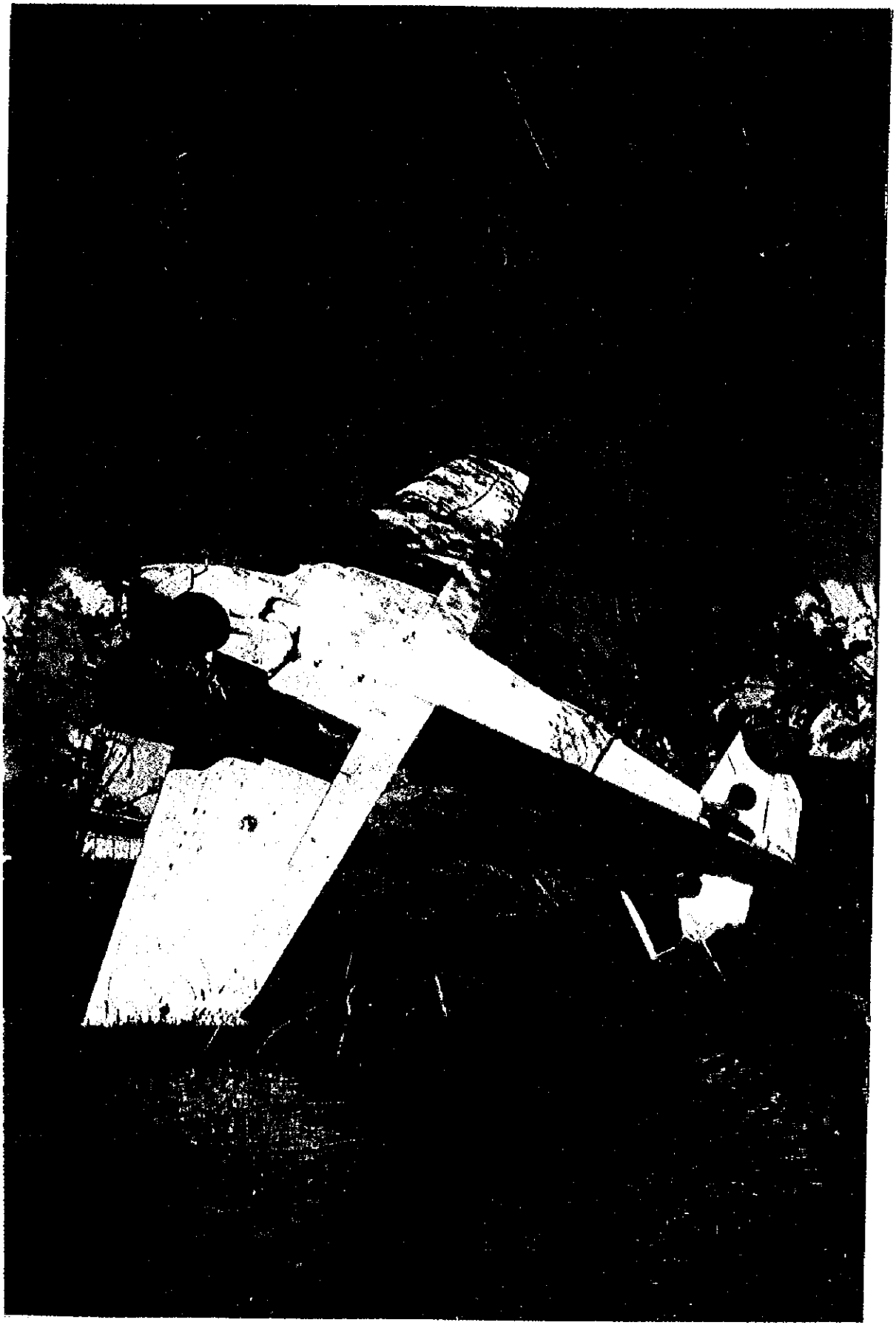
WHO

序文

米州保健機構

米州保健機構（ＰＡＨＯ）は世界最古の歴史を持つ国際保健機構であり、加盟国は南北アメリカから３５カ国、さらにヨーロッパからも三国の政府が参加し、その版図は西半球全域である。これらの国々は、保健と生活水準向上を目指しその努力を結集している。
本部をワシントンＤＣに置き、ＰＡＨＯは米州諸国のための地域オイフイスとして貢献するとともに、国連の特別組織としての機能を有する。米州機構との合意の下に、ＰＡＨＯは米州内の保健機能を司る特別機構の役割を負っている。

ＰＡＨＯ及び、ＷＨＯの使命とは、病気と闘い、平均寿命を延ばし、人々の肉体的精神的健全を促進するため、西半球における国々の努力を促し、協力作業を推進することである。この使命を遂行するため、ＰＡＨＯは、構成メンバーの諸国の保健、及び社会保障関係省庁、及び保健、教育、環境、さらには農業部門の各国省庁と協力している。さらに通常、政府関連の国際機構、あるいは、非政府国際機構とも協力している。



ＰＡＨＯ及びＷＨＯの災害対応と救済計画

２０年以上も前になるが、ペルーで大地震があり６万６千人が死亡した。１９７２年、クリスマスのたった２日前、同じ状況で１万人のニカラグア人が死亡。１９７６年２月には、大地震で、グアテマラで２万３千人の人々が死亡した。

この短期間に起こった一連の災害事故のために、ＰＡＨＯ加盟国は、緊急準備災害救済協力計画を発足させることとなった。この計画は、国の対応ガイドライン・行動計画・要員訓練・政府関連及び非政府国際機関との間の効果的協力関係を推進する等を含めた、広範囲の責任を持つものである。

今日もこの地域における自然災害への脆弱性は従来と変わらず極めて高い。大地震はチリ、メキシコ、エルサルバドル、エクアドルで起こった。コロンビアの冠雪山ネバドデルルイス火山は突然の大爆発で、２万３千人以上の死者を出し、溶岩と泥流・岩屑・灰の流れの下にアルメロの町はほとんど完全に埋まってしまった。ハリケーン、ギルバートとヒューゴは、カリブ、メキシコ、中央アメリカに災害の爪痕を残した。さらに大きな報道対象にならないが、洪水のような、緩慢な災害は、定期的に、カリブ、南アメリカの多くの地域を襲っている。

災害準備と救済計画

災害準備救済計画の重要な目的の一つは、災害に対し、迅速・効果的な対応を保証することである。その内容は、加盟国の保健関連機関における緊急対応プログラムの強化、災害保健計画確立・作業部会設立援助、保健省及び他の関連省庁間の緊密な協力関係促進、各国が大量犠牲者発生に対応すべく、災害現場と被害者の治療看護にあたる病院等両方における準備態勢確立といった努力を進めることである。ＰＡＨＯ及びＷＨＯは、加盟諸国に、主要病院の災害準備調査・訓練増加援助地震とハリケーンへの脆弱性を病院初期計画・設計段階の中に取り込むための支援を実施する。このために世界中から成功したプログラム例を導入することは又、貴重な教育的過程ともなる。

人材の育成・教育訓練教材開発には特に重点が置かれている。緊急準備・災害時救済プログラムは、広範囲な印刷物や視聴覚（スライドやビデオ）訓練材料を作成している。多くの場合、教育材料や訓練プログラムは、他者への譲渡を前提として作成され、その波及効果を高めるよう策定されている。あらゆるタイプの災害を対象とした、これら印刷物・視聴覚プログラムが用意されているということは、ラテン・アメリカとカリブ海諸国における、災害対応における共通の理念と対応方式を育成することとなる。

災害救助協力

ＰＡＨＯ及びＷＨＯの第二の目的は、災害を受けた諸国に供給される各種援助の調整を実施することである。

発達した現代のコミュニケーション・システムは、しばしば数分内に、世界的悲劇を国際機構に伝え、救済の手は数時間内に現地に向かう。しかし国際的援助は良くも、悪くもある。多くの場合、国が回復自立するための貢献となるのだが、頼まれもしない、何が必要かが適切に吟味されずに援助物資が届いたりすると、混沌状況を更に悪化せ、第二の災害に導くこととなる。

以下の提案は、国際保健救済援助をより効果的にするために挙げらたものである。

☆ 災害を型に嵌めて考えてはいけない　健康面に及ぼす災害の影響は、被災国の経済政治的状況・当該国の下部構造発達状況等の違いにより大きく異なる。

☆ 外国からの医療要員要請は少ない　ラテン・アメリカ、カリブ海諸国における、災害被害者対応に即時必要となる要員調達の能力を見ると、この分野の需要は少ない。最近の災害例を見ると、地域の医療要員が事故発生後２４時間内に、負傷者全員に治療を実施している。

☆ 捜索・救出・人命救助・緊急手当その他の即刻の医療処置の必要性は当初のみのに需要がある　これら需要に対する国際的援助の到着は通常遅きに失する。国際的援助を考慮するにあたり、緊急事態時が過ぎ去っていないかどうかの判断が重要である。この種の援助には、要員・特定救助機材・移動病院・変質しやすい物資があげられる。

☆ 国際援助提供者は被災国における、最も注目を浴びる援助の奪い合いは控えるべきである　援助の質や適切さは、量・金額の大小・搬入速度以上に重要である。

☆ 緊急援助とは、被災国作業と重複するものではなく、補完的なものでなければならない　ある程度の重複は、世界的規模で多くの国々や機関が、現実非現実の吟味もままならぬうちに、画一需要に対応しようとすれば、避け難い問題であろう。しかしこれも、その後の機能回復や復興再建に活用するための援助が供給されるならば、必ずしも無駄とはならない。

☆ メディアの国際緊急援助要請報道に過剰反応すべきではない　極端に悲劇的イメージをまず見せられる。しかしまず全貌を把握すべきであり、正式援助要請を待って活動にはいるべきである。

災害の後で、成すべきこと

☆ 災害後の保健に何が必要か、被災国の責任者から正確な情報を
ラテンアメリカ、カリブ海各国は、保健災害問題調整責任者（コーディネーター）を任命している。災害後、このコーディネーターは、災害被害状況を評価査定、ＰＡＨＯ及びＷＨＯ及び関心を持つ非政府機関と協力し保健上いかなる需要があるかを決定する。この情報を入手するまでは、救済物資の収集を始めるべきではない。

☆ 可能ならば、被災国政府当局・国際機関・責任ある民間国際機関に直接、キャッシュや信用の形で援助を実施する　ほとんどの救済物資は現地または近隣諸国で調達出来る。キャッシュであれば、災害前の保健環境再建にも利用出来るし、災害により緊急消費した他の国家機関からの重要物資補充を行うことも可能となる。

☆ 被災国のリハビリ・整備・復興再建期間の援助をしよう　喉元過ぎれば熱さを忘れる。災害も直後の緊急時期を過ぎればニュース・バリューは色褪せる。しかしながら、被災国は、その後資金・資源の枯渇に遭遇する。この後、被災国というものは、より大規模な修復と再建のための国際的援助を必要とするのである。

☆ 被災国及び他の機構に属する、個々の査察評価、察査チームや事実調査使節団等の作業結果を検討・調整・統合する。

推奨すべきでない供給物資

☆ 古着や靴類　多くの場合、その地域社会がこれらの物資に関しては需要以上の供給、寄贈を実施している。中古物資を送るよりも、その地域で、物資を調達することがより経済的で、便利が良く、衛生的である。この種の援助は、その地域の慈善団体やボランティア機関に委ねたほうがよい。

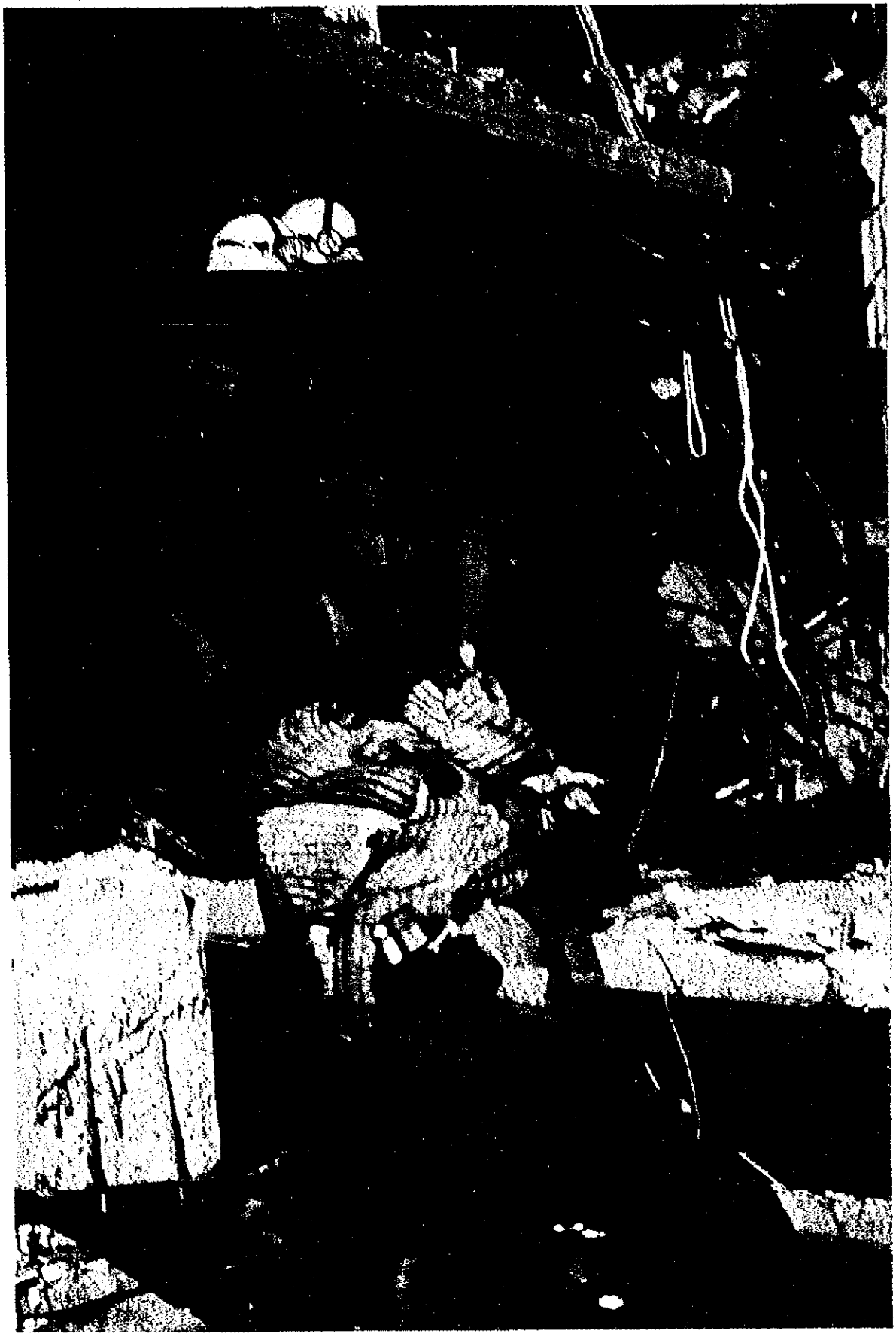
☆ 家庭用食料　同じことが、食料物資についてもいえる。たとえ国際報道機関が、地域的な食糧流通問題に脚光を当てたりしようが、ラテンアメリカやカリブ海諸国に災害に因る全国的食糧不足が発生することはないであろう。

☆ 家庭用医薬品・処方箋　医薬品は医療的にも法的にも適切でない。薬剤製品は貯蔵に場所をとられるばかりでなく、医療専門家の時間が薬品の整理、分類、表示などの作業に奪われる結果となる。

☆ 血液及び血液製品　血液への需要は通常信じられているよりは遥かに小さい。ラテン・アメリカ諸国における最近の災害を見ると、地域の献血は充分に災害による緊急需要に対応している。血液寄付は質と安全管理の面で、適切なものではない。

☆ 薬品・医療助手・助手団　地域の医療サービス陣が災害被害者に対応できる。事実ほとんどの国が患者対医者の高い比率を誇っている。国際支援を必要とする分野は、隣接諸国が最初の２４時間において最善の供給国となる。例外は保健省が特定要求する極めて高度な専門家である。現地語や地域に不案内な医者・医療助手はむしろ家に止まっていた方がよい。

☆ 現場臨設病院・モジュラー医療ユニット　このような施設は中期間向けであることを思えば、これが完全無償供与でない限り受諾をすべきではない。施設の重量・サイズ・運賃設置費用等を保健省に送付ししその利用価値判断を求めるべきであろう。



自然災害における神話と現実

災害対応において、一般人や科学者の世界で幅広く信じられている誤謬に毒せられているのは、あに国際援助のみとは限らない。堅く信じられている神話を打ち払うのは至難の業である．以下に幾つかの例を示す。

● 神話：　被災地の人々やその地域当局者は国当局は、余りのショックと無気力感のため自身の生存への責任も取れなくなる。

現実：　災害の被害者は、依存的でもなく、行動不能に陥ったものでもない。多く人々がメキシコ地震の後、生存者を探すため、自発的に結集して何千というボランティアによって証明されるように、緊急機関を通じて、新たなる強靭さを身に付けている。又、ラテンアメリカのほとんどの国が、優れた総合的な医療サービスを持ち、相対的に、人口当たりの医者の比率が高い。

● 神話：　災害後は大衆ワクチン・キャンペーンが、公共医療優先事項である。

現実：　即席のワクチンキャンペーンは、多くの理由によって、勧められるのもではない。多くのワクチンは、災害の広がりを抑制するのに土壇場での投与ではあまり有効ではない。さらに、大いに有効であるものでも、十分な効果を導き出すのに、一回以上の接種を必要とし、効果が十分となるには数週間を必要とする。即席の免疫キャンペーンは、従事者や経済的資源の意味においても、かなりのコストの浪費である。

● 神話；　自然災害は、深刻な食糧不足を起こす

現実：　この広く行き渡った神話は、多くの災害の後、ムダな食糧の寄付をもたらしている。食糧入手法は、災害の種類によっても、多種多様である。一般に地震は、食糧の入手に対する直接影響はあまりない。洪水やハリケーンに関しては、もし収穫が、被害に遭えば、大いに影響を与える。しかし、災害の種類に関わらず、食糧救済決定は、慎重にされるべきである。食糧流通は輸送手段と要員とを必要とするが、これも他の目的に使用した方が有用かも知れない。

自然災害削減国際１０年計画

国連は、１９９０年代を自然災害削減国際１０年計画（ＩＤＮＤＲ）と名付けた。ＩＤＮＤＲの目的は、自然災害によって起こる生命・財産喪失、社会経済秩序破壊、特に開発途上国に削減をめざすものである。下にＩＤＮＤＲの特定目的を列挙する。

☆　災害の結果を緩和するため、国の能力を向上させる。
☆　現存の科学技術情報の適用を高める戦略・ガイドライン制定。
☆　災害に関して、知識と情報における重大なギャップの確認。
☆　技術情報を広く周知せしめる推進運動。

ＩＤＮＤＲ事務局はジュネーブに位置し、各国政府・学界・各国ＩＤＮＤＲ国内委員会の活動を調整する。国連一般総会要請により、世界１００カ国以上が、それぞれの国内災害分野の学際的専門家から構成させるＩＤＮＤＲ国内委員会を発足させている。ＩＤＮＤＲは世界の問題点を発見し、焦点を合わせるのにこれら国内委員会を活用している。ＩＤＮＤＲは更に世界各地からの２５人の専門家からなる科学技術委員会を組織しており、これがＩＤＮＤＲに問題の本質指摘を行う。この他に世界的に高名な人物からなる特別高級審議会を持ち、これは活動の広報周知、政府民間各層からの支持取り付けに専念する。

今後数年間、本１０計画は以下の研究作業に従事する：

☆　災害管理経営学、特に災害救済における費用対効果。
☆　将来の投資が脆弱性を増大させず、災害への暴露を減少させる方向でなされる為の、対災害脆弱性評価を国家開発計画の中に統合する。

自然災害であれ、人災であれ災害が発生すれば全ての国がリスクに巻き込まれる。ラテンアメリカ及びカリブ海諸国の国々の保健厚生当局はそれぞれ、緊急時対応計画、定期的テスト、国家計画への批判と改善、保健施設の脆弱性等を当面の活動対象としている。一方、ＰＡＨＯ／ＷＨＯの災害対応及び救済計画は明日の災害への準備を今日の内に行うべく整備充実を重ねている。

米州保健機構の災害対応防備活動に関する、さらなる情報が必要な折りには下記のいずれかにご連絡下さい。

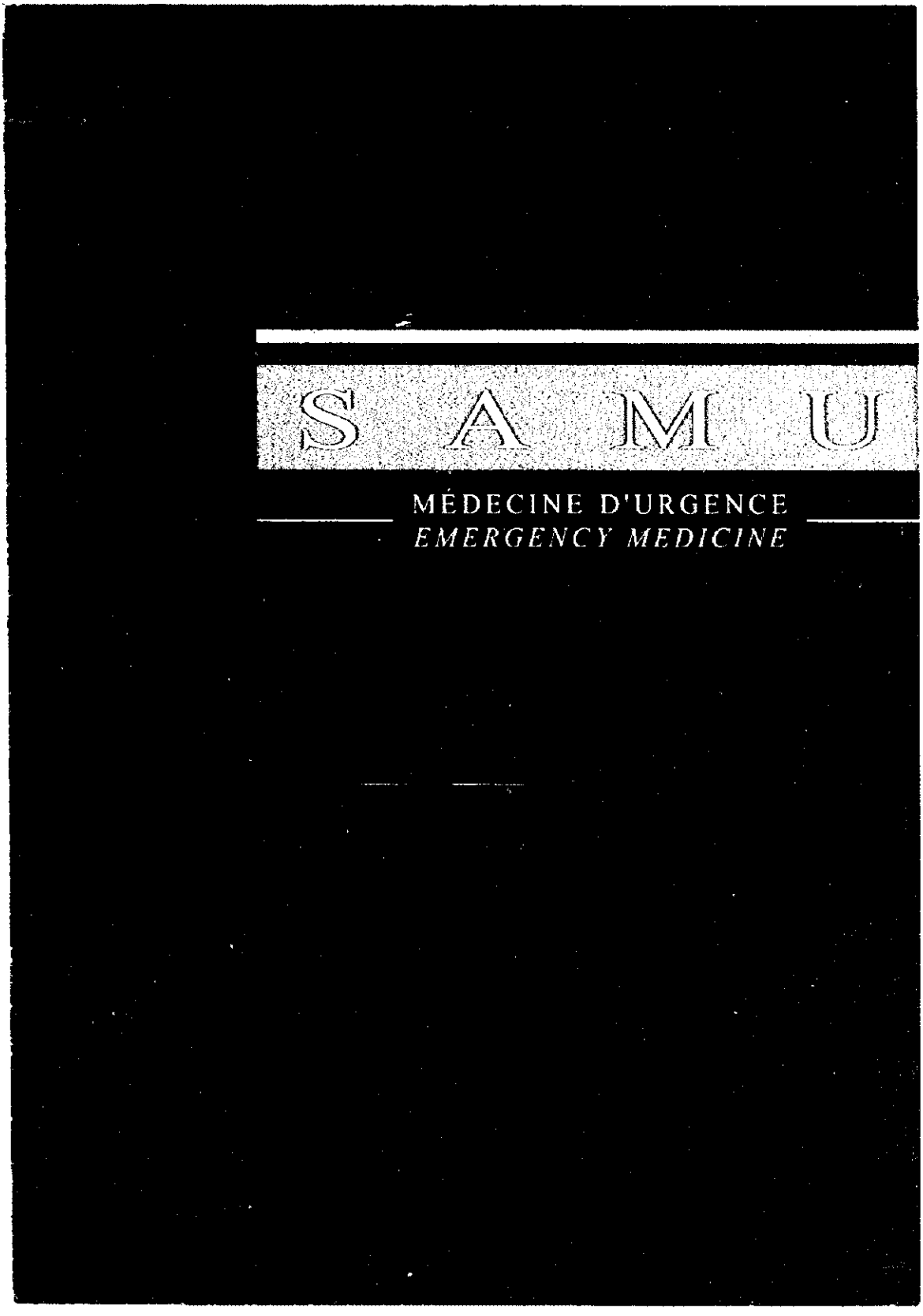
米州保健機構（ＰＡＨＯ）
緊急対応災害救済プログラム

Pan American Health Organization
Emergency Preparedness and Disaster
Relief Coordination Program
525 Twenty-third Street, N.W.
Washington, D.C., 20037 USA
Tel: (202)861-4325 ● Fax: (202)775-4578

世界保健機構（WHO）

World Health Organization
Emergency Relief Operations (ERO)
20 Avenue Appia
1211 Geneva 27, Switzerland
Tel: (4122)791-2752 ● Fax: (4122)788-2036

(11) SAMU



米州保健機構

・保健機構（PAHO）

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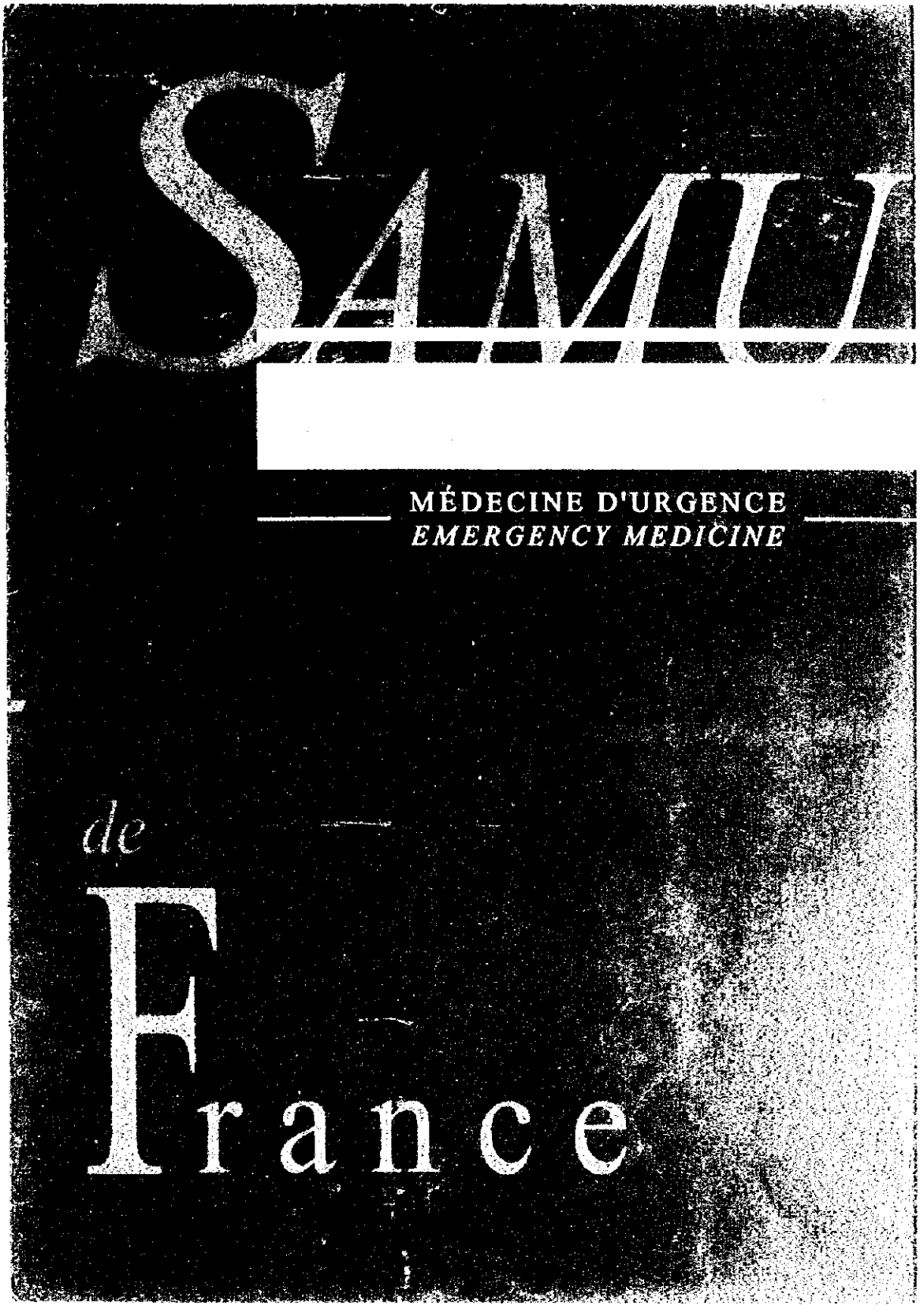

SAMU
MÉDECINE D'URGENCE
EMERGENCY MEDICINE
de
France

Des soins spécialisés délivrés sur les lieux mêmes de l'accident

Specialized medical care given at the site of an accident

Humanitarian action. Wherever possible, SAMU teams aid in countries hit by disasters.

Des équipes des SAMU de France participent à des missions humanitaires dans les régions frappées par une catastrophe.

Why have a SAMU ? *The day-to-day services provided by the French SAMU bring patients the fastest and most efficient medical care, improved moral and physical relief as well as appropriate subsequent health care orientation. In this way, the SAMU contributes to an optimal use of resources. Finally, a technically advanced medical emergency system is also most useful in implementing epidemiological and preventive research.*

Pourquoi un SAMU ? La pratique quotidienne des SAMU français apporte aux patients des soins médicaux plus efficaces et plus précoces, un plus grand confort physique et moral et une orientation appropriée. Le SAMU contribue ainsi à l'optimisation des ressources. Enfin, un système performant de médecine d'urgence est également d'un très grand intérêt pour mettre en œuvre des programmes de recherche épidémiologique et de prévention.

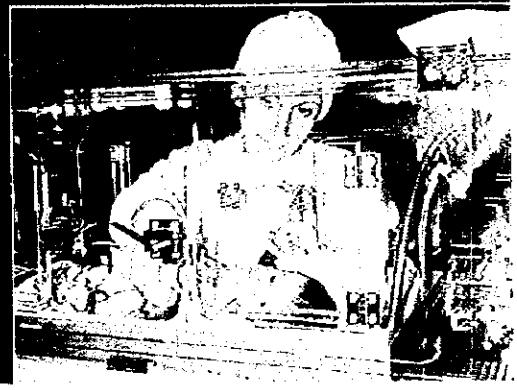
French skill *in the medical emergency area is based on a long in-the-field experience in France and has been enriched by the partnership with several foreign teams. French physicians are present in some twenty countries where they assist by surveying material resources, by evaluating structures, competences and practices, by training staff, and by designing specific systems for optimal use of local resources in order to ensure that all people have an equal access to emergency medical care.*

Le savoir-faire français dans le domaine de l'urgence médicale repose sur une longue expérience de terrain en France enrichie du partenariat avec plusieurs équipes étrangères. Des médecins français participent, dans une vingtaine de pays, à l'inventaire de tous les moyens disponibles, à l'évaluation des structures, des compétences et des pratiques, à la formation des intervenants, à la conception cas par cas d'un système permettant l'optimisation de l'usage des ressources locales et garantissant à tous un égal accès aux soins d'urgence.

SAMU
Service d'Aide Médicale Urgente

The French Ministry of Foreign Affairs *supports the SAMU's activities and has contributed in the making of this brochure. The French Embassy Services are especially helpful in arranging medical contacts abroad.*

Le Ministère Français des Affaires Etrangères soutient l'action du SAMU de France et a contribué à la réalisation de cette plaquette. Les services des Ambassades de France facilitent tout particulièrement les contacts médicaux dans ce domaine.



Human contact as well as medical and operational competency is important in each case. The patient's confidence influences possibilities for action. Respecting his dignity and desires is one of the medical team's first, most concrete, acts.

L'approche de chaque cas est humaine tout autant que médicale et opérationnelle. La confiance du patient conditionne les possibilités d'actions.

L'Aide Médicale Urgente est le premier pas, de soins d'urgence

Emergency Medical Assistance is the first, decisive step in

Humanitarian action. Whenever possible, SAMU teams aid in countries hit by disasters.

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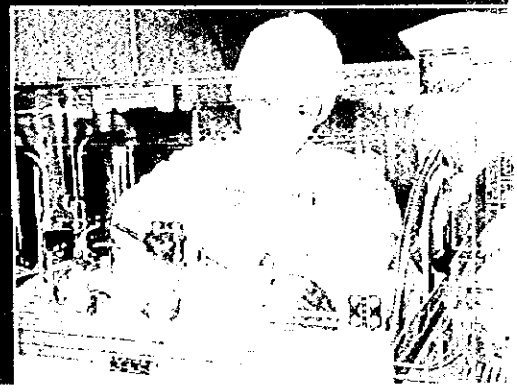


L'Aide Médicale Urgente est le premier pas de soins d'urgence

Emergency Medical Assistance is the first decisive step in

décisif, dans le processus

the emergency care process

Emergency medical care in France is based on four principles.

1- COORDINATED EMERGENCY CARE NETWORK

Private general practitioners throughout the country ensure emergency care to the public and alternate in receiving on-the-home calls requested.
Firemen and ambulance drivers provide emergency transportation for patients.
Health care centers, both public and private, take part in the regional emergency organization plan.

2- IN-THE-FIELD INVOLVEMENT BY HOSPITAL PHYSICIANS

Since the 1960s, the 350 hospitals equipped to receive emergencies have made use of "Mobile Intensive Care Units". These mobile units have two main tasks:

- *to treat the ismack on the site where the victims are and during transport to the hospital, by using a "preventive treatment" such as respiratory assistance, the administration of hemodynamics or analgesia, and such a "curative treatment" such as thrombolysis when a patient has the onset of a myocardial infarction at home;*
- *to establish a diagnosis for on-the-spot treatment, but also to decrease the patient's frustration and to prepare his hospital admission.*

3- MEDICAL DISPATCHING

Free and simple access to a Receiving and Dispatching Center for medical emergencies calls is available to everyone by telephone through a unique number id. est 15). At the Center, a dispatching physician determines the most suitable steps to be taken, orients, recommend action, dispatch the medical physician, an ambulance, or, for the most serious cases, a hospital based medical mobile intensive care unit. If necessary, the dispatching physician then directs the patient toward the hospital service most adapted to his case and takes care of his admission.
There is a Center in each "department" (a "department" in France, as a low-administrative district with a population of approximately 500,000 inhabitants).

4- HOSPITAL RESPONSIBILITY

In France, hospitals are the cornerstone of emergency medicine.
The law entrusts the responsibility for:

- *managing and making work of the Medical Emergencies Receiving and Dispatching Centers, as well as of the staff involved in the pre-hospital phase and in hospital reception;*
- *managing mobile intensive care units;*
- *building just-in-time emergency care.*

In the end, the pre-hospital and hospital services are closely coordinated. The hospital provides the pre-hospital team with an indispensable technical environment and the best possible ongoing training. The medical intervention team optimizes and facilitates the use of the hospital's resources, for which it is partially trained.

L'organisation de la médecine d'urgence en France repose sur quatre piliers.

1 - UN RESEAU COORDONNÉ DE SOINS D'URGENCE

Les médecins généralistes privés assurent à la campagne comme à la ville, des gardes pour le service public des urgences, et effectuent, chaque fois que cela est nécessaire, des visites au domicile des patients.
Les ambulanciers et les sapeurs pompiers assurent le transport en urgence des patients.
Les établissements de santé, publics (hôpitaux) ou privés (cliniques), sont inclus dans des schémas régionaux d'organisation des urgences.

2 - DES MÉDECINS HOSPITALIERS SUR LE TERRAIN

Depuis les années 60, les 350 hôpitaux habilités à recevoir les urgences mettent en service des Unités Mobiles de Soins Intensifs (UMSI)

- pour traiter les victimes sur les lieux mêmes de leur détresse et durant leur transport, à la fois avec une "thérapeutique préservative", telle que la ventilation contrôlée, le maintien de l'hémodynamique, ou l'analgésie, et avec une "thérapeutique curative" comme la thrombolyse au domicile du patient, au tout début de l'infarctus du myocarde ;
- pour établir un diagnostic, dans le but de délivrer des soins immédiats, mais aussi de déterminer l'orientation du patient et de préparer son accueil hospitalier.

3 - UNE RÉGULATION MÉDICALE

Le public accède par un numéro téléphonique simple et gratuit (le 15) à un Centre de Réception et de Régulation des Appels médicaux d'urgence. Là, le "médecin régulateur" détermine la réponse la plus adaptée et la met en œuvre : information, conseil, envoi d'un médecin généraliste de garde, d'une ambulance ou, pour les cas les plus graves, d'une Unité Mobile de Soins Intensifs hospitalière. Si nécessaire, il oriente ensuite le patient vers le service le plus adapté à son cas et fait préparer son accueil.
Il y a un Centre par "département" (entité administrative de 500 000 habitants environ).

4 - LA RESPONSABILITÉ DE L'HÔPITAL

L'hôpital est, en France, le pivot de la médecine d'urgence.
La loi confie à l'hôpital la responsabilité :

- des Centres de Réception et de Régulation des Appels, et donc de la coordination de tous les intervenants dans la phase pré-hospitalière et dans l'accueil hospitalier ;
- des Unités Mobiles de Soins Intensifs ;
- des services d'accueil des urgences.

Ainsi, le pré-hospitalier et l'hospitalier sont-ils très solidement articulés. L'hôpital apporte aux équipes pré-hospitalières une indispensable évaluation et la meilleure formation continue possible. L'équipe médicale des unités mobiles optimise et facilite l'utilisation des ressources hospitalières qu'elle connaît partiellement.

L'Hôpital sort de ses murs

The hospital extends beyond its walls

An individualized response. The "dispatching" physician calls appropriate resources into play depending on the seriousness of each case. Three advantages result :
1 - the patients most urgently in need of care benefit without delay, from the most efficient means available to them
2 - specialized medical teams intervene only in the most serious cases.
3- the most advanced resources, which are inevitably rare and expensive, are used to their best advantage ●

Une réponse adaptée.
Le médecin régulateur met en action des moyens proportionnés à la gravité de chaque cas.
Trois avantages en découlent :
1. les patients les plus sévères bénéficient sans délai des moyens les plus performants qui leurs sont réservés ;
2. les equipes médicales spécialisées n'interviennent que sur les cas les plus lourds ;
3. les ressources les plus performantes, nécessairement rares et coûteuses, sont utilisées au mieux

After a short conversation, the dispatching physician decides on appropriate action based on the patient's medical needs.

Le médecin régulateur, après un dialogue bref et précis, détermine la réponse la plus adaptée au besoin médical du patient et la met en œuvre

The most suitable orientation.
The closest hospital is not always the most suitable one. SAMU allows transporting patients directly to the most appropriate regional treatment center ●

L'orientation la plus appropriée
L'hôpital le plus proche n'est pas toujours celui qui convient le mieux. L'existence d'un SAMU permet un transport direct vers l'établissement de soins le plus approprié de la Région

All the available resources of a region
are accessible to patients through a vast coordinated emergency care network, which integrates both public and private first aid stations, primary health care units and hospitals ●

Toutes les ressources disponibles
d'une région sont accessibles aux patients dans un vaste réseau coordonné de soins d'urgence intégrant l'ensemble des moyens de soins primaires et de soins hospitaliers, publics et privés

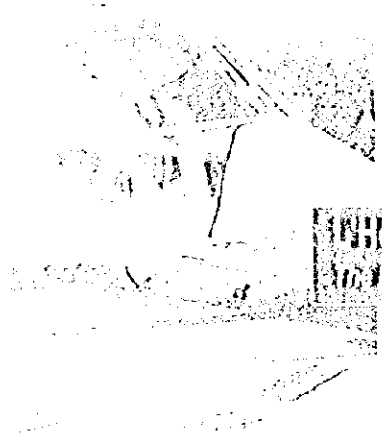
An evaluation is necessary
Although it is especially difficult (and although the methodology is not yet perfectly designed), evaluation must go along with every health care process, in emergency medicine just as in other fields ●

Une nécessaire évaluation
Bien que cela soit particulièrement difficile et que les méthodes pour y parvenir soient encore incertaines, l'évaluation doit aujourd'hui accompagner tout processus de soins, et la médecine d'urgence n'y fait pas exception

Une écoute médicale permanente

Appel anonyme, gratuit, service santé

décisif, dans le processus



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2 - specialized medical teams, intervening [illegible]
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3- the most advanced resources, which are [illegible]
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Une réponse adaptée
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Trois avantages en découlent :
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2. les équipes médicales [illegible] les cas les plus lourds ;
3. les ressources les plus performantes, [illegible] rares et coûteuses, sont utilisées [illegible]

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All the available resources [illegible] are accessible to patients [illegible] emergency care network [illegible] private first aid [illegible] hospitals.

Toutes les [illegible] d'une région [illegible] réseau coordonné [illegible] des moyens [illegible] publics [illegible]