

**HUMANITARIAN MEDICAL LOGISTICS
RESEARCH PROJECT
-
TERMS OF REFERENCES**

Washington, Dec. 2014

“LOGISTICS CONSTRAINTS AS MAIN OBSTACLE TO PROVIDE EMERGENCY MEDICAL ASSISTANCE”

Project Reference: R001 – December 2015

Project Mission:

The outcome of the project should ultimately help the humanitarian community to provide a more appropriate, effective and safer humanitarian assistance in acute emergency situation through an advanced logistics support adapted to medical programs.

Abstract:

Over the past years, repeated criticisms have been expressed regarding the failures from the international humanitarian community to provide an effective assistance in acute emergency situations. Some international organisations have recently point out the tardiness and the lack of impact of the UN agencies and INGOs response to displaced populations between 2012 and 2013. Although, most of the criticism have been raised in the aftermath of large-scale natural hazard (tsunami, Indian Ocean – earthquake Haiti), there is today a more specific concern regarding of a systematic deficit to effectively address medical needs during the recent humanitarian crises generated either by armed conflicts (e.g. Syria, CAR, South-Sudan) or large-scale epidemics (e.g. Ebola outbreak, Western Africa).

This deficit to address most accurate medical needs has led to devastating consequences on the affected population and victims of the conflicts, but also put at high risk the few international teams who struggled to provide healthcare assistance in these fields. The security concern is even more accurate when it comes to operate in remote places, where access to the affected population is more difficult due to higher logistics constraints. Without powerful and adapted logistics, it is assumed today most of the international aid agencies are opting for a non-medical assistance (NFI, food, shelter, etc.) or/and sub-contracting some more hands-on local organizations when it comes to healthcare. When logistics constraints are creating minor impediments – as it was the case during the response to the Typhoon Hayian in Philippines last year - larger and more effective humanitarian deployments have been reported.

A research project has been requested by a multi-disciplinary group in order to analyze, document and confirm if the above described dis-engagement of the INGOs from medical first-aid is indeed a consecutive effect of a lack of logistics adapted to healthcare programs (also called medical logistics) or is not. If this assumption is confirmed, the research should also i) highlight the main impediments INGOs are facing to provide appropriate medical logistics support, ii) provide related recommendations in order to guide the humanitarian community on areas of improvements and further investments related to medical logistics that should be considered in the future.

Requesting entity:

The request to develop this project is part of the demand for support that has been expressed during the multi-disciplinary workshop dedicated to Humanitarian Disaster Response held in Washington in December 2014 under the sponsorship of the U.S. National Science Foundation. The project will be supervised by an independent steering committee grouping humanitarian logistics practitioners, social scientists and researchers specialized in logistics.

Project submission:

The organisation that will be selected to conduct this project should provide the necessary human / financial resources, the methodology and the timeframe that will be necessary to achieve the objectives of the research as describe in this Term of References. Both single and joint submissions between several organizations will be accepted and selected according to the ToR requirements.

Required profile:

The project should be conducted under the leadership of an academic department from a university, a research institute or a business school) that is specialized in transport, logistics and/or supply chain. The selected research team should have some experience in medical or pharmaceutical logistics, with – if possible – a capacity to communicate both in French and English. All reports related to this project will be done in English.

Background:

During the past years, a gradual deficit of the international humanitarian community has been repeatedly reported when it comes to provide an appropriate and effective medical assistance in acute emergency situation. Talking about the on-going Ebola outbreak in western Africa, Peter Maurer, the President of the International Committee of the Red Cross, was recently deploring that “the aid arriving in the field is too slow, with insufficient quantity and is not effective enough”. Some are trying to explain this deficit by the tardiness of the international community’s financial mobilization, others would argue that the largest aid agencies were overwhelmed with other major crises when the outbreak was confirmed, others again would incriminate the lack of reactivity from the World Health Organization despite the repeated warnings from the organization Doctors Without Borders (MSF) on the unprecedented aspect of the outbreak in April, and the out-of-control reality in June. Finally, some are highlighting the extremely high level of exposure faced by the healthcare workers who are engaged in the fight against the virus¹. Although all those elements could somehow explain the deficit of the international assistance to provide assistance to the Ebola victims, there is more and more convergent indicators that are underlining logistical constraints as the main reasons behind this deficit. Last July, a research conducted by MSF - in interaction with other aid agencies in the field - has ranked logistics constraints as the first cause that explains the tardiness and the lack of impact of the UN agencies and the INGOs in emergency situations that occurred between 2012 and

¹ In November, More than 300 health workers have been reported killed by the Ebola virus since the beginning of the crisis.

2013. However, similar observation can be done for more recent crisis, such as CAR, South Sudan, Syria and recently the Ebola outbreak. The disengagement process of the INGOs regarding emergency medical assistance – also referred as humanitarian demedicalization - is not new. The extreme contrast observed between the over-sized mobilization of the international community triggered by the earthquake in Haiti and – 9 months later – the quasi-absence of response to the unparalleled cholera outbreak that has killed 7.000 people from Oct. 2010 and March 2011 is one element among others that confirms the humanitarian demedicalization has past roots. During this cholera outbreak, only two organisations have been reported treating 80% of the patients. Here again, the inability of the IONGs and UN agencies to deploy, maintain and supply cholera treatment units in Port-au-Prince and other affected areas in Haiti has been highlighted by many field practitioners. The same observation was reported during the cholera outbreak that killed thousands of people in Zimbabwe on year before². More recently, the response to the Syrian crisis confirms two recurrent characteristics in conflict situations: 1) there is a striking difference in regards to the humanitarian mobilization for natural disasters compared to conflict situations 2) the few international NGOs that are responding to this type of context are usually not ready to bring direct medical assistance to war victims³. Without adequate logistics, they prefer to use local organizations that are more hands-on. During the past nearly four years, it is essentially the Syrian population and Diasporas that have provided aid to the most affected population. As a result, their criticisms in regards to the humanitarian response are getting fierce: international agencies working in opposition held areas are accused of behaving like donors from their back offices in Lebanon, Jordan or Turkey. This Syrian example could confirm many humanitarian actors are increasingly concentrating only on the easiest-to-reach populations and ignoring the more difficult places. Because of logistics constraints, they are now working at arm's length through local NGOs or government authorities, acting more as technical experts, intermediaries or donors than field actors. However, local actors often do not have the skills or the experience required to conduct technically difficult interventions; further, it can be difficult for them to operate in contested areas and to be seen as neutral and impartial (e.g. Ukraine 2014). In the Philippines response to Typhoon Haiyan, for example, where there is good access, funding and visibility, the UN and INGO community has deployed a massive response which has been largely effective, although very costly. Nevertheless, most of this response was dedicated to non-medical assistance (NFI, food, shelter distribution programs).

Finally, the deficit of medical assistance has logically devastating effects on the affected populations and victims who will not receive sufficient and effective emergency healthcare, as it was the case last September when people infected by the virus could not be admitted in the Ebola Treatment Centers (ETC) in Monrovia because lack of available beds, and had to die in the street. Similar problems of access to emergency care have been regularly reported in the wake of heavy shelling in Syria where acute wounded people had to be transferred to Turkey because emergency rooms from Syrian hospitals were already overcrowded, many of them dying on their way to Turkey. The lack of international response is also generating a significant fatigue and higher risks to the health workers that are operating in the acute phase with regular tensions and violence registered in the admission areas of the treatment centers and hospitals that are saturated.

² By 10 January 2010 there had been 98,741 reported cases and 4,293 deaths making it the deadliest African cholera outbreak since 1993

³ Only the Qatari Red Crescent and MSF has been reported operating in northern Syria with a permanent presence of international health workers

Global objectives:

It is proposed today to document and analyze the demedicalization of the response from INGOs to emergency and acute humanitarian situations in link with logistics and supply chain constraints, and promote/stimulate further actions aiming at improving the situation.

Specific objectives:

1- Provide as much as possible a comprehensive picture of the main international stakeholders that are involved in medical logistics support to humanitarian emergencies: volume/location of activity, type of medical programs⁴, context of intervention (conflict, outbreak, natural disaster, displacement of population), modus operandi (direct / indirect assistance), etc.

2- Identify the main logistical / supply chain constraints and challenges faced by the international actors when it comes to provide direct medical assistance in emergency situation and the operational consequences in response to major humanitarian emergencies (see most reported logistics challenges).

3- Suggest a list of recommendations that should be considered by the humanitarian community – including institutional donors and governments – to guide INGOs in increasing their logistical capacity and competencies according to the identified challenges.

Main assumptions:

- INGOs are facing high challenges to provide a direct medical assistance in emergency situation;
- One of the major obstacle to effectively respond to medical needs is related to logistics constraints;
- Medical assistance in emergency situation is highly complex and required specific, powerful and adapted logistics.

Reported logistical challenges:

- Increasing logistics and supply chain constraints are mainly related to drug importation, pharmaceutical procurement and required cold chain / temperature-controlled set-up;
- Fierce competition to purchase critical items in the wake of a sudden large-scale emergency;
- Insufficient recognition and investments in medical logistics both from INGOs and donors;
- Lack of sufficient and adequate support from the World Health Organization and from the Logistics Cluster both at global and field levels;
- Quasi-absence of training dedicated to medical logistics in humanitarian response;
- General lack and slowness of funding systems from institutional donors dedicated to healthcare programs in general, specifically when it comes to logistics preparedness plan and medical stockpiles;

⁴ Secondary healthcare (including war surgical/trauma activities, reproductive surgery, burnt treatment), primary healthcare, reproductive healthcare, mental healthcare, vaccination (routine + campaign) and treatment against epidemics (meningitis, measles, yellow-fever, cholera, hemorrhagic fever, ..) and other infection diseases (TB, HIV-Aids)

- General mix-up between commercial logistics (CL) and humanitarian logistics (HL) with consecutive misinterpretation of what should be the minimum requirements for supporting humanitarian response in medical emergencies that are essential to a rapid and effective logistical deployment (fleet management, air operations, facility and asset management, WHS, energy, ITC, etc.);
- Difficulty to secure the logistical deployment and maintenance of emergency programs in a growing hostile environment.

Project support:

The Steering Committee (SC) in charge of the supervision of this project will ensure a close monitoring and provide a regular feedback to the research team regarding the evolution of the project. The SC should also guide and help the research team to identify and bridge with the foreseen stakeholders that should be interviewed in the scope of the research project.

Foreseen stakeholders:

UN agencies and affiliated

- World Health Organisation - Logistics Division
- UNICEF – Logistics Division
- PAHO
- UNRWA
- UNHRD

Inter-agency coordination

- IASC
- Logistics Cluster
- Health Cluster

Red Cross/Crescent movement

- ICRC – Logistics division
- IFRC – Logistics department
- French Red Cross
- American Red Cross
- Qatari Red Cross
- Palestinian Red Cross

Pharmaceutical Procurement – Donation Center

- MSF Supply
- MSF Logistics
- OCA - Procurement Unit
- AIDA
- Tulipe
- Quamed

Independent INGOs

- Médecins Sans Frontières
- Emergency
- International Medical Corps

- Save the Children International
- International Handicap
- Médecins du Monde
- Medicare
- International Refugee Council
- Goal
- Care international
- Mercy Corps
- Islamic Relief Worldwide
- ACTED
- Concern
- World vision International

Institutional donors

- ECHO
- USAID
- DIFID

Academia – Research

- Bioforce Institute
- URD
- GeorgiaTech

Private companies - suppliers

- Kuhne & Nagel
- Maerks
- DHL
- UPS
- Baxter
- DuPont

Other stakeholders

- CDC

References:

- *“Where is everyone? Responding to Emergencies in The Most Difficult Locations” – MSF – July 2014*
- *Joint Evaluation of the Global Logistics Cluster- Konterra Group – Aug. 2012 (point 151)*
- *GHA – Global Humanitarian Assistance – 2014 report*
- *Emergency Humanitarian Logistics: Critical Review Over the Past Decade – P. B. Desbureau – Aug. 2014*
- <http://www.theguardian.com/commentisfree/2010/dec/28/haiti-cholera-earthquake-aid-agencies-failure>
- http://www.lemonde.fr/planete/article/2014/10/24/ebola-on-aligne-les-millions-mais-il-n-y-a-que-quelques-cliniques-qui-fonctionnent_4512044_3244.html

- <http://online.wsj.com/articles/ebola-crisis-stretches-doctors-without-borders-means-1417219277>