

Disasters

Preparedness and Mitigation in the Americas



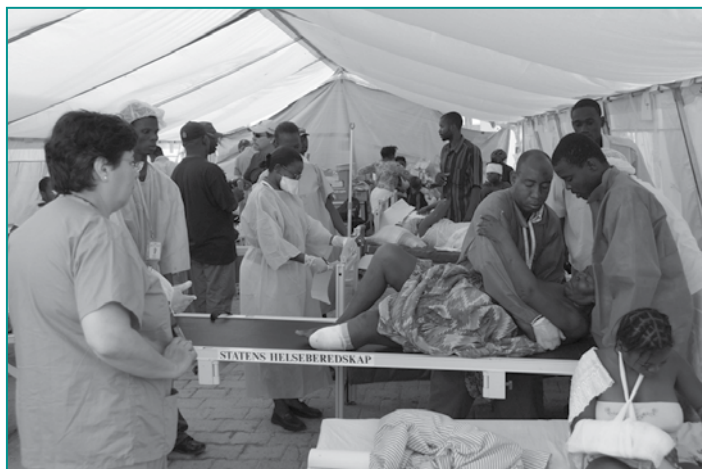
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Field Hospitals and Medical Teams in the Aftermath of Earthquakes

Editorial



the lesson was learned to be later forgotten. In the most recent disasters, few are the responding countries or agencies not sending field hospitals or medical teams.

In 2003, WHO and PAHO joined efforts and called a meeting of experts to review the situation and prepare guidelines. The objective was to transform an offer-driven autom-

atism into a demand-sensitive response. As shown in the earthquakes in Pakistan and in Haiti, the guidelines are largely disregarded. No technical recommendation or results of needs assessment seemed to influence the international rush to deliver emergency medical care.

What did we (or should we) learn from the medical response in Haiti?

1. Although arriving far beyond the golden six hours for primary emergency care, the first trauma teams did save lives and prevented serious complications. This has been rarely the

(continued on page 11)

Interview

Jeremy Collymore, Executive director of the Caribbean Disaster Emergency Management Agency (CDEMA), responds to questions about the agency's new strategic approach, the Caribbean response to the Haiti's earthquake, the role of international cooperation regarding risk management and the actions that should be taken to increase cooperation between CDEMA and the health sector among other issues.

1. It has been a year since CDERA formally became the Caribbean Disaster Emergency Management Agency with a more strategic approach in comprehensive disaster management. What progresses have been made and what are the challenges ahead?

Change, as you know, is an ongoing process and, notwithstanding that, we can comfortably say that we have made some significant adjustments to our governance mechanism. The establishment of the Management Committee of Council provides a mechanism for more direct political engagement and oversight of both the organization and the disaster risk reduction enhancement process.

We have established technical subsets, comprising the directors of the national disaster systems, into specific skill or function-related committees. This allows for more and early direct country participation in our program design and development as well as the review of these programming and related initiatives.

As a result of this deeper country participation we are already seeing the benefits in terms of fuller

(continued on page 3)



**Pan American
Health
Organization**

Regional Office of the
World Health Organization

Contents

Editorial.....	1	Member Countries.....	6
News from PAHO/WHO.....	2	Safe Hospitals.....	8
The Interview.....	3	Perspective.....	9
Other Organizations.....	4	Publications and Multimedia.....	10
New Tools.....	5	What's New at CRID.....	12

Supporting Health Services for Displaced Populations in Colombia

For several years PAHO/WHO has had a special program in Colombia to give support to and reduce the public health emergencies created by the displacement of more than 3 million people (as recognized by the Presidential Agency for Social Action and International Cooperation), due to an internal armed conflict that has ravaged the country for more than 40 years.

The Organization's efforts have concentrated mainly in the departments of Nariño, Chocó, Cauca, Valle del Cauca, Arauca, and Norte de Santander; most of them are located in border

areas with difficult conditions, intensified conflict and constant violations to the medical missions. All these factors hinder the delivery of health services to the people affected by mass displacements, particularly women, children, the elderly, and indigenous and Afro-Colombians.

In turn, these groups often find themselves unable to adapt and faced with disease, malnutrition, and ignorance and violations of their own health rights.

The health situation of displaced populations is characterized by indicators typical of social underdevelopment and exclusion, such as high mortality in children under five years old. They generally suffer from malnutrition, acute diarrheal disease, limited access to prenatal care, high morbidity and mortality in pregnant women and teenagers, low vaccination coverage, and low quality and access to health services. Unfortunately, this happens in a country where private companies, that do not find it profitable to work in such remote regions, are responsible for providing health services.

In this scenario, PAHO/WHO is working with national and regional authorities in the design of plans aimed at strengthening human resources to respond to the health risks of a complex emergency, which can occasionally be exacerbated by natural phenomena. Technical cooperation is focused on information management, interinstitutional, intersectoral and interagency coordination, health preparedness and response for the acute phase of

mass displacements and gaps in health services.

The work being done is based on an intervention plan that characterizes the displaced population, develops tools to analyze information, and promotes advocacy with national, departmental and municipal authorities to ensure that the affected population has access to health services. Training materials with an intercultural approach have been developed, that clearly show the right to health of the population and how to access those services.

Technical cooperation is also aimed at providing psychosocial support to the affected population, generating health care models appropriate to the realities of the country, implementing healthy actions that will enable them to have healthy environments, safe water for human consumption and care of primary sources in order to prevent disease and ensure a better quality of life.

Another activity is the development of contingency plans for health mitigation and response during the acute phase of the emergency. These include working with the support of Rapid Response Teams, which are located in several areas where PAHO is present. Keeping these teams together is a real challenge, because there are problems to deal with, such as high turnout, insecurity, administrative difficulties, budgets and, sometimes, lack of political will. All these factors require that strategies are created to generate sustainable processes.

Finally, another challenge of the IDP program is the establishment of more rigorous systematic processes to facilitate the compilation of experiences and fieldwork in order to extrapolate them to other areas or communities with needs and problems similar to those experienced in Colombia.

For more information write to Piedad Sanchez, sanchezp@col.ops-oms.org or check out PAHO's website for displaced populations in Colombia: <http://disaster-info.net/desplazados>.



Training for Health Professionals for Assessing the Economic Impact of Disasters

Recent disasters in the Region have once again highlighted the vulnerability of Latin American and Caribbean countries, and the great losses suffered by the economy, in general and the health sector, in particular. For example, in Haiti, the overall impact of the earthquake was US\$ 7.8 billion, which represents 121% of its annual GDP. Damage and losses to the health sector totaled US\$ 525 million.

PAHO/WHO, in collaboration with the Economic Commission for Latin America and the Caribbean (ECLAC), hosted in September, in Lima, Peru, a training session for professionals with experience in disasters on the Damage and Loss Assessment (DALA) methodology, which evaluates the socioeconomic and environmental impact of disasters. The main objective was to select participants for a health sector evaluation group.

The DALA methodology measures the impact through the addition of the damage and losses in all sectors and was developed by ECLAC; the health sector assessment was done with assistance and coordination from PAHO. Post-disaster assessments are done after the emergency phase is over, to ensure that the evaluation work will not disrupt the response efforts, but also to ensure that evaluators have a baseline. After the initial data collection and interviews with government counterparts and the private sector, field visits are conducted to estimate damages. Finally, using national accounts, losses for each sector are assessed. The information obtained provides the basis for the formulation of appeals to the international community and the identification of key projects for reconstruction.

The World Bank, UN Agencies and the European Commission have developed a process for Post-Disaster Needs Assessment and the Recovery Framework (PDNA/RF), based on DALA and on the Human Recovery Needs Assessment (HRNA), whose objective is to have a correct formulation of appeals and requests for financing and the development of projects and action plans for the short, medium and long term. This new methodology seeks to combine the assessment of the socioeconomic impact with the impact on human development, by combining the DALA and HRNA methodologies.

For more information contact Carlos Roberto Garzón (garzonc@pan.ops-oms.org) or visit www.eclac.org.

The Caribbean Disaster Emergency Management Agency's New Strategic Approach

(from page 1)

participation and more responsiveness to the requests made to our Participating States.

Internally, we have made some substantial advances in the improvement of our administrative and financial systems. We have strengthened some of our procurement and financial mechanisms which allow for deeper transparency on the services we seek to provide and solicit.

2. Haiti's earthquake occurred a few months after this country signed the Caribbean Disaster Emergency Management Agency Agreement. In that sense, how do you qualify the Caribbean response to the Haiti's catastrophe and what things need to be improved for the future? Which were the main challenges?

In the context of the available resources and institutional arrangements in support of Haiti, our response was timely as we were there in less than 48 hours. The response supported the arrangements around the national civil protection mechanism. This was important for Haiti to absorb and relate to the massive external insurgence.

Our intervention allowed us to test the operational principle of the sub-regional focal point system, in this instance the Jamaica sub-regional focal point. Haiti benefitted from the true embracement of this principle by the government of Jamaica and really facilitated that front line intervention that was critical during the initial stage and thereafter.

However, the absence and limitations of the existing arrangements for coordination and response in Haiti was a major challenge.

Our role was really to give Haiti the kind of briefing and intelligence, which was necessary to allow them to best extract, utilize and tap into the support that was being provided. As we look at the main challenges, I believe, firstly, there is a need to revisit the whole idea of the (UN) clusters to ensure that the support they provide is beneficial to the impacted states. This is a general observation that is also supported by the UN Humanitarian Coordinator.

Secondly, there is a need for responding entities to focus their support on the needs of the impacted states and the victims and less on the visibility opportunities that arise from their presence in that place. In my view too much of the Haiti support was determined by the priorities that were articulated by the responding entities as opposed to those generated by the State or the Civil Protection department.



Mr. Jeremy Collymore

3. How do you see the role of international cooperation in this issue of risk management? How can we create synergies and greater impact in reducing vulnerability, building capacity, and, above all, reducing disaster risk?

The international cooperation in disaster risk reduction generally and in response coordination in particular must be driven by the principles of "subsidiarity". What does this mean? It means that the international community should only seek to engage where there is demonstrated evidence that the country, its neighbors and sub-region cannot support due to any type of resource deficit.

This enthusiasm by international entities must be tempered by the recognition that countries do have capacities and their support should not focus on "external institutionally defined programs" but should support the implementation of nationally defined priorities and programming. This in my opinion is the biggest challenge in international cooperation in the area of risk management.

Although global initiatives in disaster risk reduction may identify broad thematic areas in which there is a global agreement for action, one must be mindful however that the global definition of a problem is not the same as the local articulation of the solution. The dynamic of generating local solutions in a global programming framework needs to be managed so that there is more connectivity between the global organizational mandates and the beneficiary (country) priorities.

4. The health sector has been one of the most active on issues of risk and disaster management, but more coordination and collaboration are still needed between CDEMA and actors in this sector. What concrete actions should be taken to increase cooperation and have a greater shared impact in the Caribbean region?

The Comprehensive Disaster Management (CDM) disaster risk reduction program has clearly identified the role of PAHO, with other institutions, in the health sector and I believe that some significant advances have been made in that direction. As part of the structured cooperation with CDEMA in relation to the health sector disaster risk reduction issues, PAHO has been identified as the lead partner in this area with responsibility for coordinating the interventions as it relates to health. The dialogue built around how to deal with the H1N1 pandemic and these new kinds of threats, not only with PAHO but with partners who were key to that process.

There is also a need now for some engagement around how information on impact and capacity is captured, inventoried and feedback into the central CDEMA database and capacity monitoring mechanism. We believe that the program and monitoring framework that is being elaborated for the CDM health program will move us in that direction.

I would not hesitate to say that the health sector is a good demonstration of efforts at mainstreaming the risk issues in sector programming and also at interfacing with the larger CDM programming. What we may need now is to reduce the frequent change in, or long periods without, leadership of the PAHO program in the Caribbean if outcomes and visioning is to be sustained.

There is also a need to develop programs that recognize the realities on the ground and not be driven by program implementation schedules of our institutions/agencies. Presently our resources are time driven by projects and most times the project schedules do not reflect the realities of implementation on the ground so you always have a gap between where the project wants to go and what realistically can be achieved. This confirms the need to have a more programmatic approach to cooperation and implementation and a dialogue of our partners in support of that principle.

Read the full interview in the online version of the newsletter: www.paho.org/disasters/boletin.

The HELP course offers useful tools for disaster situations

The International Committee of the Red Cross created the HELP (Health Emergencies in Large Populations) course in 1986 to enhance professionalism in humanitarian assistance programs in emergency situations.

Since 1986, it has been taught in various parts of the Americas, Asia, and Europe, and training has been provided to approximately 2,700 health professionals and humanitarian aid workers from the Red Cross, United Nations agencies, nongovernmental organizations, ministries of health, armed forces medical services, and academic institutions.

The course has been organized in collaboration with academic institutions, the World Health Organization, the Pan American Health Organization, the World Medical Association, and National Red Cross Societies.

It consists of two modules. The first provides the public health tools needed to make appropriate decisions in emergencies involving large populations. It lays the groundwork for a shared approach to public health issues among humanitarian organizations, thereby helping to better coordinate emergency operations. It covers specific areas such as planning, nutrition, economic security, environmental health, communicable disease control, health services, mental health, and epidemiology.

The second module examines health-related ethics issues. It provides an overview of the main legal instruments; international humanitarian law, especially human rights instruments; professional codes; and declarations that are the basis for decision-making in humanitarian operations.

In the Americas, the course will be given in Spanish in November 2010 in Cuernavaca, Mexico, in collaboration with the National Public Health Institute. It will be given in English from 10 January to 21 January 2011 at John Hopkins University in Baltimore in the United States. For more information please visit one of the following websites: http://www.icrc.org/web/eng/siteeng0.nsf/html/help_course or http://www.jhsph.edu/refugee/education_training/help/.

International Day for Disaster Reduction, 2010: "Making Cities Resilient: My City is Getting Ready!"

Belts of chronic poverty, growing populations, inadequate housing, unplanned development, and insufficient infrastructure plague many cities and urban centers and help to intensify the impact of natural threats. These vulnerable conditions for urban inhabitants are compounded by climate change and weak local governance in facing risks and disasters.

The Hyogo Framework for Action 2005-2015: **Building the Resilience of Nations and Communities to Disasters** provides recommendations on how local governments can manage and reduce urban risks. Risk reduction provides opportunities for capital investment through the upgrading of infrastructure and the modernization and reconditioning of buildings for greater energy efficiency and security, urban renewal and modernization, the use of clean energy, and the improvement of rundown neighborhoods.

In particular, with the 2010-2011 campaign: "Making Cities Resilient: My City is Getting Ready!" the International Strategy for Disaster Reduction (ISDR) and its partners are working to raise awareness about the benefits of sustainable urbanization. There are sufficient grounds: when risk reduction strategies are successful, poverty is reduced and there is increased growth, jobs, social equality, and business opportunities, balanced ecosystems, and better health and education.

Since local governments are the institutional level closest to citizens and communities (they play an immediate role in responding to crises and emergencies and must meet the needs of their populations), the ISDR campaign seeks to convince them to commit to carrying out a list of essential activities to achieve resilient cities and work in conjunction with local stakeholders, grassroots networks, and national authorities.

These activities cover aspects such as: organization and coordination to reduce risks, the allocation of a budget, the updating of information on threats and vulnerabilities, investment in infrastructure, the application of construction standards, establishment of education and training programs, the protection of ecosystems and natural areas, the installation of early warning systems, and meeting the needs of disaster victims.

The success of the campaign will be measured by how many mayors and local governments commit to the initiative, how many partnerships and alliances among citizens and organizations are formed and how many cities show evidence of new risk-reduction plans.

As part of the celebration of the International Day for Disaster Reduction, ISDR has published a web page to promote the activities of this campaign: <http://www.unisdr.org/english/campaigns/campaign2010-2011/>.



The CDC presents a guide to the use of social networking to improve health messages

The Centers for Disease Control and Prevention's (CDC) Office of the Associate Director for Communications, Division of News and Electronic Media has made the Health Communicator's Social Media Toolkit available online to extend the reach of health messages, increase access to their content, and achieve greater transparency and public participation in order to improve communication efforts in the health sector.

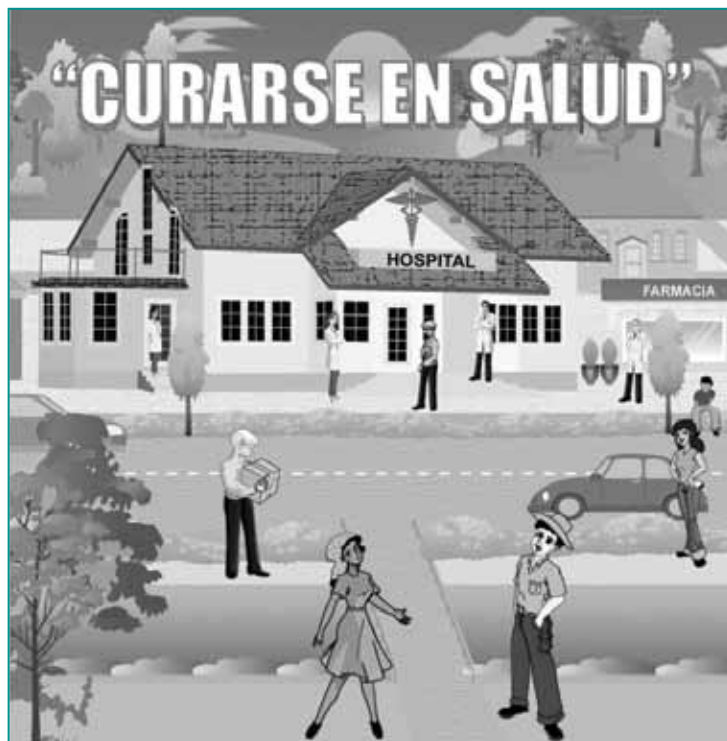
The document discusses matters such as: the use of social networking to disseminate public health mes-

sages, the available tools and the standards that should govern them, recommendations, lessons learned by the CDC in the use of social networking, guidelines for developing strategies to integrate social networks into an organization's communication efforts, graphic resources, and technical applications.

The Toolkit can be consulted at: <http://bit.ly/dpdOOK>.



New Radio Show on Disaster Reduction



highlight local risk reduction capacities and promote safer communities.

The series involves four separate stories: “*Cuando el río sueña...*” (Where there’s smoke...) highlights the work of community authorities in putting an early warning system in place; “*Lo que bien se aprende*” (What is well learned) emphasizes the rights of children and the care they should receive during an emergency; “*Curarse en salud*” (Heal in health) narrates the efforts of a structural engineer to ensure that standards are adhered to and the construction of a safe

The story “*Curarse en salud*” shows the difficulties many communities in our Region face in building health centers and hospitals that can continue to operate at full capacity during and after an emergency.

The story mentions the importance of conducting simulations in hospitals and health centers and of planning these entities’ responses to emergencies and disasters.

Each of these radio soap operas encourages the public to think about ways to achieve truly safe communities, what can be changed, and the impact of disasters on economic development, children, and health.

In addition to their broadcasting on local radio stations, the radio soap operas will be used as supplemental tools during workshops on disaster risk reduction. They are innovative alternative instruments for the educational system and non-governmental organizations working in risk management.

UNDP, PAHO/WHO, UNICEF, Ayuda en Acción, and UN-HABITAT also participated in the production of “*Vida que te quiero tanto*.”

For more information about this tool, contact Margarita Villalobos at margarita.villalobos@eird.org.

“*Vida que te quiero tanto*” (Life, I love you so much) is a series comprised of four radio soap operas produced by the United Nations International Strategy for Disaster Reduction and the International Federation of Red Cross and Red Crescent Societies. Its goal is to

hospital is guaranteed; and “*Quien siembra vientos*” (Whomever sows winds) shows the management skills of a community leader in setting up a temporary shelter, relocating the community, and renegotiating debt for small farmers and businesspeople.

Specialized Portal on Public Health and Risk Management

The specialized portal on public health and risk management of the Regional Disaster Information Center for Latin America and the Caribbean (CRID) is now online. The portal has a total of 800 information resources divided into different sections to give users easier access to the available information on general risk management and health; health sector organization and policy; health preparedness; the health sector response; safe hospitals; pandemic and emerging diseases; cooperation and humanitarian assistance.

This new information resource is the result of close collaboration between CRID and the Pan American Health Organization (PAHO/WHO) and the product of a lengthy effort to review ma-

terials, information resources, and technical documents.

This work is part of CRID’s efforts to offer the public information that is more specialized, better organized, and more suited to its needs and interests. It is also one of a line of CRID products designed to meet the demand for information on public health and risk management.

To visit this website, go to: <http://saludydesastres.crid.or.cr> or visit the CRID home page at: <http://www.crid.or.cr>.

For additional information on this or other products, contact: Isabel López: isabel.lopez@crid.or.cr or Irene Céspedes: irene.cespedes@crid.or.cr.



Member Countries

Haiti, a long road to recovery after the earthquake

Close to 1.3 million remain displaced in 1,354 spontaneous settlement sites across the country

Ten months after the earthquake in Haiti, the situation regarding housing, health services, provision of food, and disease control remains fragile because the population continues living in highly vulnerable and unhygienic conditions. The current cholera outbreak has presented the authorities, the population and the humanitarian actors with a new challenge.

In the coming months the main challenges will be the control of the epidemiological situation, appropriate care of patients, prevention of environmental hazards (water quality, promotion of hygienic and sanitation measures), security in camps, reconstruction, resettlement and preparedness measures for the presidential elections at the end of November. It is expected that a large-scale humanitarian operation will remain a reality in Haiti for at least one year or longer.

Close to 1.3 million people remain displaced in 1,354 spontaneous settlement sites across the country. To meet the health needs of this population, 21 international organizations are covering 266 sites. It is estimated that 661,000 people have migrated and are living with host families. Roughly 12,300 transitional-shelters have been built which house over 60,000 people on newly developed land.

The health cluster has been fundamental in improving coordination and strategic planning



among different humanitarian actors, and its partners are working with the International Organization for Migration (IOM) and others to ensure health needs are addressed when families move from spontaneous settlement sites to transitional shelters.

Respiratory infections, diarrhea and psychological trauma are chronic problems in camps and show no signs of abating.

The Health Cluster

PAHO/WHO remains the key liaison between the Presidential Commission and international health partners. Given the continued large presence of national and international health NGOs, the Health Cluster in Port-au-Prince plans to remain operational through early 2011 and likely longer.

Use of the LSS/SUMA System in Pakistan Extends beyond Emergencies

The significant advantages offered by the Logistics Support System (LSS/SUMA) in managing humanitarian supplies during an emergency are widely known. However, there is another reality: the distribution of humanitarian aid continues long after the news coverage of the emergency, and use of the system continues for months and even years after the disaster.

This is precisely the case in Pakistan, where a program was set up after the 2005 earthquake by a logistics team from the World Health Organization (WHO), with support from personnel mobilized from the Americas. The system was initially set up in WHO/Ministry of Health warehouses in Islamabad and later at affected sites and distribution centers in Muzaffarabad, Bagh, Rawalakot, Mansehra, and Battagram.

Once users had been trained by the WHO/PAHO team, they became instructors in how to

use the program in other locations, bringing together at least 21 organizations that helped manage medicines and made suggestions that led to a new version of the LSS. This new version of the program includes aspects such as special reports with different deadlines, inventory levels, and reports by sector or storage location, as well as the improvement of lists that make it possible to print data subsets based on the assistance needs that arise.

Daily use of the system also enabled health authorities and the WHO office to have a Pakistani team that reacted quickly and efficiently to the floods in Sindh and Baluchistan (2007); the earthquake in Baluchistan (2008); the displacements (2009), and most recently, the floods that have been hit large areas of Pakistan since August 2010. In the latter case, implementation of the program in eight districts of Punjab has helped

detect shortages in medicines and medical supplies and maintain an appropriate logistical chain by providing updated reports on supplies and distribution.

The Pakistani team found the following advantages to using the LSS:

- The system helps classify donations by type, donor, and priority. This makes it possible to evaluate inventory levels and examine neglected categories, and to generate reports from different sites where the distribution and use of assistance are being coordinated.
- The classification of medicines by "therapeutic category" helps experts suggest alternatives to a medicine.
- Better regulation of inventories shows current supplies and those that are lacking. Designation of minimum and maximum control points makes it possible to regulate the de-

Recognizing that relief operations extended far beyond Port-au-Prince, PAHO/WHO, with support from the Ministry of Health, opened a number of field offices to establish subnational health clusters in Leogane, Jacmel, Cap-Haitien/Port-de-Paix, Jimani and the Haiti-Dominican Republic Border. The national and sub-national clusters coordinated treatment of the injured and affected, evaluated short- and medium-term needs, and mapped capacity of health sector activities.

The cluster in Port-au-Prince is chaired by the Presidential Commission for Health with PAHO/WHO serving as the secretariat. In collaboration with technical areas of the Ministry of Health such as mobile clinics, vector control, and malaria diagnostics, cluster leadership continues to craft strategies for health services at the national and sub-national level. Investigations find that many camps still do not have health care services and in some cases the mobile clinics are just tents with a box of drugs. A team of PAHO health services experts are working to address these shortfalls in coverage through training, provision of supplies, and partnerships with NGOs.

Field Operations

In Jacmel—a city in the department of Sud-Est, which borders with the Dominican Republic—27 out of the 42 health institutions were seriously damaged. The most significant damage was suffered by St. Michel Hospital, which serves 500,000 people. It is estimated that the population increased 10% following the disaster.

In May, MSH Spain helped with repairs of the St. Michel Hospital with the construction of two semi-permanent buildings that house the pediatric and internal medicine units, and has also been providing services there along with Save the Children and International Medical Corp.

In Leogane, although the number of NGOs active in this area is decreasing, major institutions like MSF-Switzerland, Save the Children, Merlin, and The Johanniter remain active. MSF-Switzerland is running the only functional hospital in Leogane.

The Haiti-Dominican border has been active since just after the earthquake. PAHO/WHO initially sent a team to Jimani to help the affected population who fled Port-au-Prince and surrounding areas. A field office was established that acted as a logistical hub and also supported local health facilities, which received over 3,000 patients in the first few days. In recent months, PAHO/WHO has been active in establishing the public health services network in the Dominican Republic border provinces. The expected results are a more robust public health response, capacity building for providers addressing nutrition, and strengthening of water and sanitation infrastructure. The PAHO/WHO border project is expected to run through early 2011.

This article is a summary of the report published by PAHO/WHO on 4 October 2010; the complete report can be consulted at www.paho.org/disasters.

Cholera Outbreak in Haiti



PAHO/WHO is collaborating with health sector partners to fight the recent cholera outbreak in Haiti. The work strategy centers around prevention at the community level, strengthening first level treatment centers for the treatment of mild cases and the establishment of specialized centers for the treatment of more severe cases.

At the close of this edition, Haiti's Ministry of Health had confirmed more than 4,000 cases and more than 300 deaths due to the disease. In addition to Artibonite, where initial cases were reported, cholera had spread to other departments. Previous experience with this disease suggests that more cases will continue popping up in the next few years.

We will have complete coverage of the outbreak in Haiti in the next edition of the newsletter.

mand for supplies during the rehabilitation phases.

- The monitoring and graphic representation of distribution ensures coverage for missing supplies in priority areas.
- Data from previous years helped in the drafting of contingency plans and the relocation of supplies in vulnerable locations.
- It was possible to construct an institutional record by provider, based on purchases and conduct.
- Flexible use of calendars by expiration date and designation of levels ensure that no medicine expires due to lack of review.

Other implementation experiences for the daily use of LSS/SUMA

During the October 2007 crisis in Lebanon, a PAHO/WHO team was called to support the



Ministry of Health in receiving supplies during the crisis. Six months later, a project initiated by EMRO/WHO in Cairo permanently implemented the system in the Ministry of Health's central warehouse, from which medicines were periodically distributed to all health centers in Lebanon, including controlled medicines that were sent to hospitals and health centers.

The LSS also supplements institutional systems

by helping to manage categories that cannot be entered directly into the institutions' accounting systems, serving as a flexible tool for managing supplies and assisting coordination by providing information on supplies and the distribution of supplies to all related agencies.

This was the case for Birmex (Biológicos y Reactivos de México) which not only used the program to manage assistance received for the A(H1N1) emergency, but also to manage the donations and supplies it administers on behalf of organizations like the National Center for Children and Adolescents.

Birmex has also helped with the selection of a large number of vaccines, which have been incorporated into LSS/SUMA in specific facilities and will facilitate management of the information for other users.

For more information, please contact Víctor Martínez at martinev@paho.org.

Ministries of Health Support a New Plan of Action on Safe Hospitals

Ministries of health throughout the Americas called for new efforts to make hospitals disaster-safe, so that they can continue to provide health services when they are urgently needed.

During their meeting at Pan American Health Organization (PAHO) headquarters in Washington, D.C., health leaders endorsed a new regional Plan of Action that includes planning, investment, and inspection systems to ensure that hospitals and other new health facilities are built in accordance with disaster-resilience standards and that the oldest facilities are modernized so that they can keep operating during emergencies.

According to the Directing Council, reaching the goal of disaster-safe hospitals by 2015 requires the preparation of a regional plan of action with extensive participation by PAHO/WHO Member States.

The Council asked PAHO/WHO to support and promote action to achieve the goals laid out in the new Plan of Action; develop technical instruments and guidelines to facilitate the monitoring of progress in the implementation of the plan; and promote the strengthening of partnerships to mobilize human and financial resources and the technology required to improve the safety of health services in disasters.

In several countries, responsibility for achieving the goal of safe hospitals rests with or is shared by national multisectoral disaster-reduction bodies, involving other sectors inside and outside the health sector. However, the participation of other sectors is still very limited in the majority of countries, making it difficult to include the Safe Hospitals Initiative in specific medium- and

PLAN OF ACTION ON SAFE HOSPITALS	
Objective	Goals
1. Develop and implement a national safe hospitals program and policy.	By 2011, 80% of the countries will have established a national safe hospitals program.
2. Develop and implement information systems to rapidly identify all new construction, repairs, or improvements in the health infrastructure so that measures can be established to guarantee their operation in the event of an emergency or disaster.	By 2013, 90% of the countries will have an information system on the construction of new hospitals or the improvement of existing hospitals.
3. Establish and implement supervision and control mechanisms for hospital construction work and other investments in health facilities.	By 2013, at least 80% of the countries in the Region will have established mechanisms for the supervision of hospital construction work and other investments in health facilities.
4. Guarantee the introduction of criteria for protecting lives, investment, and operations during all stages of the new health investment projects.	By 2015, all countries will have included measures that guarantee the operation of health facilities in the event of a disaster in all new health investment projects.
5. Update the design, construction, and operating standards for health facilities to protect structural, nonstructural, and functional components in the event of a disaster.	By 2015, 90% of the countries will have up-to-date standards for the design, construction, and operation of new, safe health facilities.
6. Improve the safety of existing health facilities, giving priority to those that are an essential part of the health services network in emergencies and disasters due to their importance and complexity.	By 2015, at least 90% of the countries will have improved the safety of the existing health facilities in disasters.

long-term actions. The creation of safe hospitals is complicated by competition with other priorities such as rising needs in other areas of public health, limited budgetary resources, high rates of staff turnover, and lack of human resources in health. Moreover, hospital safety is not considered a social value.

On a positive note, technical knowledge and policy decisions indicating an interest in working toward safe hospitals are already in place. The complete plan of action can be viewed at: http://new.paho.org/disasters/index.php?option=com_content&task=view&id=989&Itemid=&lang=en.

ECHO Continues Supporting the Safe Hospitals Initiative in Central America

The European Commission's Office of Humanitarian Aid and Civil Protection (ECHO) has once more given its backing to the Safe Hospitals Initiative and has approved the Seventh DIPECHO Action Plan for Central America, which emphasizes the strengthening and safety of health services in emergencies and disasters. Activities under the new plan will be carried out at the national, departmental, and municipal level, prioritizing the strengthening of local capacity, given its importance in emergency response.

"Safe Hospitals and Urban Risk: Safer Cities in Central America with Health Systems Prepared to Respond to Disasters" is based on lessons learned

in the previous DIPECHO project and the campaign of the International Strategy for Disaster Reduction: "Making Cities Resilient: My City is Getting Ready!" Part of the premise is that cities cannot exist without safe health facilities.

Training will continue for evaluators who will apply the Hospital Safety Index; and the index will be applied to evaluate health facilities in Honduras, Nicaragua, Guatemala, and El Salvador and to develop pilot plans to reduce vulnerability. Thus, the objective is to achieve sustainable investment in urban risk reduction by promoting the protection of infrastructure, strengthening the operating capacity of health facilities, and forging

partnerships with national and local authorities.

The plan also includes the design of a geographic information system, to be developed by the Water Center for the Humid Tropics of Latin America and the Caribbean (CATHALAC). To this end, several departments in two Central American countries will be chosen and their health facilities, security level, and natural and man-made hazards mapped.

For more information on the project write to Carlos Roberto Garzon at cgarzon@ecu.ops-oms.org.

Avoiding the Urbanization of Disaster Risk

The International Federation of Red Cross and Red Crescent Societies has just published the World Disasters Report 2010: Focus on Urban Risk. This article is a summary of chapter 1, which was written by David Satterthwaite, Senior Fellow, International Institute for Environment and Development (IIED). We acknowledge IFRC for their agreement in allowing us to disseminate the chapter. The complete report can be consulted at: <http://www.ifrc.org/publicat/wdr2010/summaries.asp>.

The early part of 2010 saw two of the worst earthquakes of recent times strike separate parts of the Americas. An 8.8 magnitude earthquake hit Chile, a country which had just joined the OECD (Organisation of Economic Co-operation and Development) club of wealthier nations, and caused widespread damage to property but the death toll was counted in hundreds. It followed an earthquake of slightly lesser magnitude in January which struck Port-au-Prince, the capital of the region's poorest country, Haiti, and resulted in more than 200,000 deaths according to best estimates and left more than 1 million people homeless. The disparity in the impact of these two earthquakes is in part explained by the differences in disaster preparedness and the quality of housing, infrastructure and services.

A disaster-prone urban future can be avoided. Trend is not destiny. But as the world's population becomes increasingly concentrated in large cities, we are seeing an urbanization of disasters and disaster risk. This presents rapidly evolving challenges for international agencies, NGOs, and central and local governments in how they approach disaster response in an urban setting, particularly in low-income countries where endemic poverty underpins vulnerability to disaster events.

United Nations projections suggest that almost all the world's population growth in the next few decades will be in urban areas in low and middle-income nations. Much of this population growth is currently in informal settlements where housing conditions are generally very poor and even the most rudimentary protective infrastructure is often lacking. A high proportion of this urban growth is in cities at risk from the increased frequency and intensity of extreme weather events and storm surges that climate change is bringing or is likely to bring. But a city can be among the safest places when a storm, flood or earthquake hits. Most extreme weather events in high-income nations cause no fatalities.

But urban areas need separate consideration because their very character – the concentration of population, homes and other buildings, transport infrastructure and industry – presents both problems and opportunities for disaster risk reduction

and humanitarian assistance. Urban populations also need some consideration simply for their scale: by 2010, there were 2.5 billion urban dwellers in low- and middle-income nations; most of the world's largest cities are in low- and middle-income nations.

An overall view of UN estimates suggests that around 1 billion urban dwellers live in poor-quality, overcrowded housing in slums or informal settlements.

The links between urban poverty and disaster risk are likely to be increased by climate change. Tens of millions of urban dwellers face, or will soon face, life-threatening risks from the increased intensity of storms, flooding and heatwaves that climate change is bringing, with associated threats to their livelihoods, their asset bases (including housing), environmental quality and future prosperity.

The crisis of urban poverty, rapidly growing informal settlements and growing numbers of urban disasters arises from the failure of governments to adapt their institutions to urbanization. Often this failure is linked to their weak financial status, lack of trained staff and lack of capacity due to the refusal of central and provincial governments to provide them with resources commensurate with their responsibilities. Perhaps the most important issue that runs through all the chapters in this report is that city and municipal governments should be working with their low-income populations and other vulnerable groups to take disaster risk out of urban development and expansion.

If national and international databases on disasters become more precise and comprehensive as to the impact on individual cities, it is certain that the observed trends would reinforce the view that disaster risk increases in badly governed cities and decreases in well-governed cities. Observed trends would also show that many city governments increase disaster risk as they ignore the population living in informal settlements or as they bulldoze these settlements, destroying the homes, assets and livelihoods of tens of thousands of people but providing no alternatives.

Greater consideration is needed of the role that housing plays in urban areas for low income

groups such as the hundreds of thousands of slum dwellers rendered homeless by the January 2010 earthquake in Haiti. The value and importance of housing to such groups far exceeds its monetary value. What seems to outsiders to be no more than a shack built mostly of temporary materials is actually the home with all its key attributes for family and social life, privacy and safety, and is the primary defence for those living there against most environmental health risks.

To relocate those made homeless by a disaster to 'safe' places far from where they have income-earning opportunities simply compounds still further the disaster's impact and most will not stay there. It also has great relevance for any initiative to improve housing conditions because most households in an informal settlement are far better served by in-situ upgrading than by moving them to new housing in a new – almost always worse – location. And it should not be only those with proof of land and housing ownership that get help for rebuilding.

The greater the control of local residents, both individually and as a community, the more successful the support is likely to be. The strong emphasis of this year's *World Disasters Report* is on supporting community-level initiatives because in almost all low-income and most middle-income nations, this is the only way to ensure that the needs and priorities of those most at risk from disaster are addressed.

This report has enough examples of good practice from low- and middle-income nations to show that urban disaster risk reduction is possible but these are still the exceptions.





New Response Guides from PAHO/WHO

Mental health and psychosocial support guidelines



This document was drafted with a psychosocial and community approach. Its main purpose is to detect and anticipate problems and strengths from a community perspective. It was designed as a tool that is easy for emergency response teams to use and implement. As a matter of priority, it is geared to primary health care teams and people, institutions,

or organizations that work with these teams to provide emergency care and humanitarian assistance.

The main reference sources used in drafting these guidelines were the *Practical Guide for Mental Health in Disaster Situations*, published by PAHO/WHO in 2006, and the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, published by the Inter-Agency Standing Committee (IASC) in 2007.

Emergency and disaster simulations and drills

The guidelines regulate the organization, implementation, and evaluation of simulations and drills, and provide suggestions on the different uses for these exercises within the context of emergencies and disasters. The purpose of this tool is primarily, but not exclusively, to support health organizations in reviewing

and modernizing their preparations for and responses to emergencies and disasters.



This new edition of *Damage Assessment and Needs Analysis in the Health Sector in Disaster Situations* (DANA) analyzes the characteristics of the DANA and provides format models for collecting and assessing health information. The purpose is to base decision-making on good technical information that

Evaluation of damages and analysis of health needs in disasters

makes it possible to efficiently diagnose, prioritize, and plan interventions and solicit resources.

The publication emphasizes the organization of the health sector from the formation of an emergency operations committee to a health situation room—a structure that should be reproduced at the national, regional, and local levels.

These publications can be consulted at: www.paho.org/disasters.

Humanitarian Action Report 2010



The *Humanitarian Action Report* is the annual appeal from UNICEF on behalf of children and women affected by emergency situations throughout the world. This report offers a general overview of financing needs, information about emergency situations in different regions and countries and provides human interest stories. It highlights the invaluable work of partner agencies in resolving the needs of children in an increasingly complex humanitarian environment.

This year's report shows that the world is witness to crises worsened by tendencies that are bigger than any one agency's capacity can face; it also emphasises situations that require exceptional support to save lives and protect children from mistreatment.

The report is available at: <http://www.unicef.org/har2010/index.html>.

Interagency radiation emergency plan

The third edition of the *Joint Radiation Emergency Management Plan of the International Organizations* is currently available. It describes the interinstitutional framework for preparing the response to a real or potential nuclear or radiological emergency.

The document describes the regimen for participating international organizations to respond to any nuclear or radiological emergency, including a conventional emergency with radiological implications, and measures for developing exercises, among other things. It contains aspects related to planning, response, and preparedness for an emergency of this type.

The document is available at the following Internet address: http://www-pub.iaea.org/MTCD/publications/PDF/EPR-JPLAN_2010_web.pdf.



case in other disasters. In Haiti, the small size of the country, mere number of casualties and the severe disruption of the poor pre-existing hospital capacity ruled out any hope of national self sufficiency. Indeed, in India national health services were more than capable (if not necessarily prepared) to meet all the needs for health care in Gujarat. In Iran, foreign field hospitals started to arrive long after the last wounded from the Bam earthquake had been evacuated and redistributed over the 13 provinces. In Pakistan (Kashmir, 2005) logistical challenges and a population thinly spread over mountainous terrain prevented timely arrival and reduced the impact of most external medical facilities.¹

2. Quality of services was variable: from the disaster-experienced and organized teams to the publicity-seeking individuals with unproven skills and competence. Unfortunately, offering “medical care” was the most popular entry point or pretext for pursuing other objectives be they personal, religious or political.²
3. Speed and local flexibility was far more important than technology and sophistication. Small mobile teams from places as far apart as Florida or Europe saved far more lives than the best equipped hospital ships arriving much later.
4. Collaborating with local structures and integrating Haitian health staff into the foreign teams, an indispensable condition for a harmless exit, was far too rare. The Red Cross Movement spirit of support to the local society is not always emulated by other actors. The progressive integration of Haitian personnel into the pediatric team sent by the Swiss Cooperation and their well-planned handover to the University Hospital was also an exception noted by the health authorities.
5. If there was an initial acute shortage of medical care, rapidly it turned into an uncoordinated flood of competing initiatives resisting the supervision from an otherwise seriously disrupted local Ministry of Health.

The main lesson is perhaps that the humanitarian community just did not seem to learn lessons! The tendency to call the latest catastrophe as “unprecedented” is a disguised and convenient way to suggest that the excess and failures bear little relevance for the next disaster!

No technical recommendation or results of needs assessment seem to influence the international rush to deliver emergency medical care.

The WHO/PAHO guidelines, however imperfect they may be, were just not heeded.

Why?

The main reason is that the problem is not technical (better specifications and norms), it is political. Adjusting medical response to needs will be similar to the arduous selling of the concept of “safe hospitals”: Norms were refined and adopted by experts in a matter of a few years...with little impact on even the construction of new facilities! Pressure had to be built through conferences, high visibility public awareness campaigns and sensitization of decision makers for what they occasionally see as an inconvenient long-term concern competing with their most pressing priorities.

Then what should be done about this dysfunctional medical response?

1. Reject the fallacy that the Haiti earthquake is so unprecedented that “not too much” should be learned from it! If one thing, the Haiti tragedy confirms how actual the PAHO video on myth and realities remained! A full compilation of observations and systematic documentation of health errors and failures need to be compiled and published. Memories, especially humanitarian ones, are very short.
2. Review the 2003 PAHO/WHO guidelines on field hospitals. Indeed, some aspects of the impact and response in Haiti were not foreseen and need to be considered in a new version. The scope of the guidelines should also be broadened and include medical teams. Large medical/surgical capacities deployed in Haiti did not consider themselves to be “field hospitals” and therefore not subject to the 2003 norms! This review will be initiated at a meeting of experts in December 2010 in Havana, Cuba.
3. Widen the debate on key issues such as:

- a. When is it too late for immediate trauma care?
 - b. Where is the right balance between sustainability and ambitious “minimum requirements” for humanitarian assistance? In other words, when does providing too much medical assistance during a short period of time may become detrimental?
 - c. How to internationally support and enable medical staff and volunteers from the affected or neighboring countries to play a greater role in the medical response? Local or regional volunteers may be more adapted and available but are often marginalized by their lack of the most basic logistic capacity and material resources.
 - d. How to insure quality control of the health assistance provided. Professing to be “accountable to the beneficiaries only” should not be a license to provide substandard care. Registration and accreditation (certification) of potential foreign medical teams is an avenue being explored with the support of DFID and the Swiss government. How to, and who should do this accreditation?³
4. Mobilize, sensitize and involve political decision makers: It is a global issue that should be approached at global level. The topic should be discussed from the ECOSOC meetings and the WHO Health Assembly to the Regional Committees and national forum. This cannot be done without some participation of the mass media. As for many subjects, it is a too serious matter to be left to the experts or practitioners only.

Let's hope that reflecting about the errors and shortcomings of the response to recent earthquakes and the tsunami will create this political will indispensable for any collective progress. It is time to transcend the good intentions and mold them into a broader view of the short and long term interests of the affected population that we all serve.

A group of experts, from PAHO/WHO and other agencies, will revise the existing guidelines on the use of foreign medical teams and field hospitals in emergencies and disaster situations at a meeting that will be held in Havana, Cuba, from 6-8 December 2010. We will publish the results from this meeting in the next issue of the newsletter.

1. Simple Cuban “field hospitals” consisting in fact mostly of mobile primary health care teams were more efficient and appreciated than large trauma care facilities from traditional donor countries.

2. Lancet 2010 Editorial: Growth of aid and the decline of humanitarianism. www.thelancet.com. Vol. 375, January 23, 2010.

3. *Ibid.*



The **Regional Disaster Information Center's (CRID)** mission is to promote the development of a culture of prevention in Latin American and Caribbean countries through the compilation and dissemination of disaster-related information and the promotion of cooperative efforts to improve risk management in the Region.

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Virtual Library of the Ministry of Health of El Salvador's Disaster Program, available on DVD

The Ministry of Health of El Salvador is offering its users a digital version of the technical documentation on prevention, preparedness, hospital planning, and emergency and contingency plans prepared by its Health and Disaster Emergency Preparedness Program.

This initiative has received technical and financial support from PAHO/WHO and the Regional Disaster Information Center for Latin America and the Caribbean (CRID). To access the virtual library, go to: <http://www.crid.or.cr>.

Second edition of the collection of tool catalogs

The revised second edition of the catalogs of information tools and resources on early warning systems (EWS), health, education, and the strengthening of local response capacity is available on the CRID website: <http://www.crid.or.cr>. These catalogs were prepared within the framework of the Sixth DIPECHO Action Plan.

Other new material available from CRID

- *Ensuring Haitian women's participation and leadership in all stages of national relief and reconstruction. A gender shadow report of the 2010 Haiti PDNA*. 2010.
- *Desplazamiento y cambios en salud. Ayacucho, Perú: 1980-2004*. Organización Panamericana de la Salud (OPS/OMS). Lima. 2010.
- *Health sector self-assessment tool for disaster risk reduction*. Pan American Health Organization. Washington, D.C. 2010.

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