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PROGRESS REPORT ON NATIONAL AND REGIONAL HEALTH DISASTER PREPAREDNESS AND RESPONSE

Since the Directing Council established the Area on Emergency Preparedness and Disaster Relief exactly 30 years ago, countries have made considerable progress in reducing the health impact of major emergencies and disasters, due to the continuous support of the ministries of health. The topic is now one of the eleven essential Public Health Functions recognized by the Governing Bodies in 2001. Almost all ministries have a stable disaster management unit or office. In most countries they benefit from strong political support, have a permanent structure, as well as a minimal full-time professional staff, possess a meager but defined budget, have direct access to the highest level of decision making, as well as have responsibility for covering all types of disasters (multi-hazard) and clearly reach out to other sectors. In some countries the disaster units have been marginalized in times of major emergencies due to lack of prior political support.

Training and development of technical and multimedia educational material are increasingly shifting from the regional to the country level. The wealth of material produced by nationals is shared regionally through the Regional Disaster Information Center (CRID) supported by PAHO/WHO. The Organization is progressively focusing on pioneering new topics or publishing documents of broader regional interest. Countries have also largely contributed to the humanitarian supply management system (SUMA) through the Multiagency Logistics Support (LSS), that is becoming a multisectoral tool of global interest.

One of the major shortcomings of countries in the Region is the often limited focus on imminent or seasonal hazards. The preparedness of Member States for the influenza pandemic is an example and an indicator of the current shortcomings.

PAHO/WHO has taken a number of measures to strengthen the regional health response mechanism, at the request of the Directing Council, but also taking into account the changing international context which increasingly requires a massive global response to highly visible disasters. This document proposes to complement the strengthened PAHO/WHO regional response team with the resources of key institutions in Latin America and the Caribbean which have the expertise and capacity to share responsibility for providing emergency health services. The endorsement and support from the Governing Bodies is a prerequisite for this complementary approach and to start seeking a formal agreement.

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Background

1. The Region of the Americas has a history of being vulnerable to major natural disasters. Few countries are totally immune from the risk of catastrophic earthquakes, volcanic eruptions, or climatic events (as evidenced by the destructive 2005 hurricane season in the Caribbean and the United States of America). The Region also has a history of disturbances or conflicts that have created large population displacements and affected public health. Although Latin America and the Caribbean have not experienced large chemical accidents of the magnitude of Bhopal, India, the risk is becoming increasingly credible.
2. If the risk has been present for centuries, it was only in the 1970s that the health sector in Latin America and the Caribbean recognized preparing for disasters as a priority. In 1976, following the earthquake in Guatemala (23,000 deaths), the Directing Council adopted a landmark resolution CD26.R11 “to request the director to set up...a disaster unit...” instructing the Director of PAHO to establish a unit to assist the ministries of health to prepare and plan for disasters.
3. However, accepting the inevitability of disasters was not sufficient. In 1985, the destruction of the Juarez Hospital in the earthquake in Mexico City belatedly raised the awareness of Member States of the need to mitigate, if not altogether prevent, the loss of health facilities when they are most needed.
4. Finally, hurricanes Mitch and Georges, which set back development in the affected countries in Central America and the Caribbean in 1998, helped convince Member States to include “*reducing the impact of emergencies and disasters on health*” as one of the Eleven Essential Public Health Functions (EPHF) of the ministries of health.
5. Continued support from the ministers of health has permitted the Americas to play a leadership role in health disaster management at the global level. There is, nevertheless, room for improvement. The recent Tsunami that affected 12 countries in South Asia in December 2004 and the earthquake in Pakistan in 2005 illustrated many new challenges that health authorities face both following a large-scale tragedy and an overwhelming and uncoordinated flow of assistance¹. It is opportune for PAHO/WHO and the ministries of health to reflect on their collective achievements as well as the shortcomings and to make the necessary adjustments to sustain this leadership.

¹ In its 2004 Disaster Report, the Red Cross Movement qualifies the humanitarian assistance as the “world largest unregulated industry”

6. The present progress report, which is presented 30 years after the establishment of the Emergency Preparedness Program by the Directing Council, is based on the knowledge of national conditions by PAHO/WHO staff, the visit of a senior consultant to some countries and the results of two surveys:

- A 2001 survey to measure the performance of Member States under the essential public health functions (EPHF) initiative. The results were published in 2002² by PAHO/WHO, the US Centers for Disease Control and Prevention (CDC) and the *Centro Latino Americano de Investigaciones en Sistemas de Salud (CLAISS)*;
- A 2006 questionnaire, circulated by the Area on Emergency Preparedness and Disaster Relief,³ to which 33 Latin American and Caribbean countries responded. Detailed results are contained in Document CD47/INF/4.

7. This report complies with Resolution CD46.R14 requesting “*the Director of PAHO to present a report to the 47th Directing Council regarding advances made*”:

- (a) by Member States in giving priority “*to reduce the vulnerability of their population and health facilities and to strengthen preparedness and response mechanisms for major emergencies,*” as well as
- (b) by PAHO in “*establishing a regionwide mechanism for immediate disaster response.*”

8. This report will address these two points separately.

9. More information on technical progresses in disaster risk reduction is contained in CD47/INF/4.

Institutionalization of a Disaster Unit/Office in the Ministry of Health

10. Since the inception of the program in 1976, the formal establishment of a disaster management unit or office in each Ministry of Health has been PAHO’s prime objective and indicator of success. To be effective this unit must meet certain criteria:

² *Public Health in the Americas: conceptual renewal, performance assessment, and bases for action*
PAHO scientific and technical publication No 589

<http://www.campusvirtualsp.org/eng/pub/PublicHealthAmericas/index.html>

³ WHO is planning a comprehensive disaster preparedness survey of all its Member States in the near future.

- A scope ranging from prevention/mitigation to the coordination of the response to all types of major emergencies;
- A full-time dedicated professional staff and a budget line;
- Direct access and reporting to the policy level of the Ministry;
- Broad cross-sectoral outreach.

11. Presently, 26 (79%) of the 33 countries of America responding to the 2006 questionnaire have formally institutionalized a disaster reduction program and office. In six countries, the function is assigned to another program or individual. Only one country lack either a focal point or some other ad hoc arrangement.

12. Most offices or units are modestly staffed. Only fifteen of the 33 countries have a specific budget line for disaster health preparedness. Others (eighteen countries) fund their activities through ad hoc arrangements for health disaster response, which places them in a vulnerable and precarious situation. PAHO and WHO will closely monitor this situation in periodic surveys of the status of emergency preparedness of the Member States.

13. Appropriate access to decision makers has improved, as it is now rare to see these offices buried within a technical department. In 19 countries, this program is attached to the Cabinet of the Minister or to the Office of the Director General.

14. In all 33 countries, this unit actively links and reaches out to the institutions in charge of overall disaster management and reduction (civil protection or a similar organization). Cooperation with other nonhealth actors, whose support, collaboration and/or information are essential for reducing the health impact of disasters, varies: 25 (78%) health disaster program link with Civil Defense, 28 (85%) with Red Cross, 20 (61%) with the ministry of environment, 21 disaster programs (64%) with the Armed Forces. 22 programs (67%) with international nongovernmental organizations (NGOs) and United Nation Agencies, 18 (54%) with universities, 17 (51%) with the ministry of foreign affairs and fewer (14 – 42%) with other institutions.

Capacity Building/Training

15. Member States now have at least a small group of professionals with some experience in disasters. The extent of training activities carried out by the Ministry of Health is truly remarkable. Among the best covered topics are hospital disaster planning and mass casualty management (especially in the Caribbean), damage and needs assessment, and epidemiological surveillance. Training efforts at the national and subnational levels have contributed to building a critical mass of health workers exposed to the principles of disaster reduction. This is a major departure from the early days when almost all training activities were carried out by PAHO/WHO. Partnership with

universities and professional associations is still modest, although growing in the Region. The active involvement of other institutions/sectors with expertise and a stake in this issue has increased awareness among multiple key players. Most universities have integrated some aspect of disaster preparedness in their health facilities; however, very few have developed courses on disasters.

16. At the regional level, since 2000, 11 LIDERES (LEADERS) courses have been held in the Americas to improve the disaster health risk reduction skills of a wide range of senior level professionals in many sectors. Those courses have been taught thanks to the support of Member States that have provided facilitators and a network of universities who have played a key role in organizing and ensuring academic quality. LIDERES has generated growing support from partner agencies such as UNICEF and the International Federation of the Red Cross (IFRC). Expertise is now also provided by Latin American and Caribbean countries through a network of national experts like the Disaster Mitigation Advisory Group (DiMAG)⁴ and collaborating centers in Chile and São Paulo.⁵

Technical Publications, Guidelines and Standards

17. The number of technical publications, guidelines or standards developed or adapted at the *country level* is increasing rapidly.

18. PAHO/WHO's contribution is now to compile the knowledge accumulated in the countries and produce scientific material on new or highly specialized topics of common interest, a cost-effective approach. Recent examples include the publication *Management of Dead Bodies in Disaster Situations*⁶, a companion guide to the publication *Protecting Mental Health in Disaster and Emergency Situations*, the new version of *Hospital Planning for Disasters*, updated and expanded material on drinking water and sanitation, and a series of publications on safe hospitals. Future priorities will focus on complementing conceptual documents with practical guidelines (how-to) and standards in response to needs expressed by the Member States.

19. A mechanism is in place to inventory, digitalize and disseminate the scientific material produced by the countries. The Regional Disaster Information Center (CRID), located in facilities offered by Costa Rica, is jointly managed by the International Strategy for Disaster Reduction (ISDR) and PAHO. Countries are progressively but slowly developing their own capacity to manage and disseminate information. CANDHI, a regional network of disaster health information centers in Central America, was

⁴ DiMAG is an informal group of experts from Latin America and the Caribbean who volunteer to assist governments and PAHO/WHO by providing independent advice in disaster mitigation.

⁵ Chile – PAHO/WHO Collaborating Center on Disaster Mitigation in Health Facilities; São Paulo – PAHO/WHO Collaborating Center for Disaster Preparedness in the Americas.

⁶ Jointly with the International Committee of Red Cross (ICRC) and the International Federation of Red Cross Societies (IFRC).

initiated with the support from the US National Library of Medicine (NLM). More than 25,000 hits were registered on the web sites of these national information centers supported by the NLM and European Union donors. A similar initiative is in the planning stage in the Andean countries. It reflects the ability of countries to electronically access information. However, preference remains on printed material⁷.

Reducing the Vulnerability of Health Facilities: Safe Hospitals

20. In 2005, the Governing Bodies (CD46.R14) requested Member States to give priority *“to reduce the vulnerability of their population and health facilities and to strengthen preparedness and response mechanisms for major emergencies.”*

21. It is estimated that more than half of the hospitals in Latin America and the Caribbean are located in disaster-prone areas and are unsafe. This situation is not specific to the Region; the Tsunami and the earthquakes in India (Gujarat), Iran (Bam), and Pakistan also severely affected health infrastructure. Building codes for health facilities should not only ensure the survival of staff and patients but also be stringent enough to permit facilities to continue operations.

22. The destruction of Mexico’s Hospital Juarez in 1985 and the death of 561 patients and staff prompted the Region to launch a massive awareness campaign to increase the structural and nonstructural safety of the health facilities. This concern, at first a regional issue, evolved into a global priority in January 2005, the “Hyogo Framework of Action for 2005-2015,” the global blueprint stemming from the Second World Conference on Disaster Reduction held in Kobe, Japan, included a specific indicator on vulnerability reduction in the health sector.

23. Achieving the goal of safe hospitals requires strong support from other sectors, as well as a significant financial commitment. It must be a State priority, not a sectoral one. Unfortunately, political commitment is often lacking, as funds allocated for this purpose remain disproportionately low compared to the needs. Indicators to monitor funding allocated for hospital safety, the number of engineering vulnerability analyses performed, and the number of facilities strengthened will be included in periodic country surveys being developed together with WHO. PAHO/WHO is part of several global task forces and institutions such as the International Strategy on Disaster Reduction (ISDR) and ProVention Consortium to help advocate on the critical importance of health risk reduction.

⁷ Survey carried out by PAHO/WHO in 2004.

Challenges

24. As Hurricane Katrina clearly illustrated, there is room for improvement in any country of the Region. Member States face several challenges:

- The human and financial resources assigned to the Disaster Unit must be strengthened to raise awareness and preparedness to the level that the population expects. Greater progress is needed to implement Resolution CD46.R14 urging Member States “*to continue giving priority attention to the allocation of financial resources*” intended for this purpose.
- The political support provided to preparedness activities in most countries should be extended to response in times of major crises. Occasionally, in the aftermath of large-scale disasters, political implications lead decision makers to marginalize the trained disaster coordinators.
- Preparedness efforts at the national level should be matched at the provincial or State level. National coordinators should increasingly play a normative and supportive role. Direct uncoordinated emergency interventions often weaken local institutions⁸.
- Greater attention is required to ensure continuity and professionalism. The rapid turnover of key staff, often with each change of authorities, remains a systemic problem. The very distinctive nature of disaster management, the imperative need for prior emergency experience, and the web sites of external contacts required for proper coordination need continuity. This continuity will only be achieved by considering disaster management as a specialized post with its own educational requirements and subject to competitive selection.
- Resources should be earmarked and responsibility assigned to prepare for rarely-occurring events. Programs tend to focus disproportionately on the management of common seasonal emergencies. Indeed, these disasters are a major burden for the population and the health authorities; they are also where public pressure is most felt. However, their impact on public health is relatively minimal and reasonably well controlled. As a result, insufficient sustained attention is given to the infrequent, but historically inescapable, major disasters such as earthquakes, volcanic eruptions and others.
- Finally, national programs in the Americas should adapt to the rapidly changing international humanitarian environment. This point will be addressed in the next section.

⁸ The same problem has been seen at international level where response tends to substitute rather than support the national effort.

Influenza Pandemic: A Special Case

25. The threat of a pandemic underscores the complementary roles of communicable disease experts and disaster managers. Preventing the transmission, early warning, laboratory diagnosis, protocols for treatments, and general case management calls for the expertise of epidemiologists, veterinarians and other health experts, not the special skills of disaster coordinators. Nevertheless, should a particularly lethal pandemic take hold, it will become a socioeconomic, health and political disaster, particularly given the fear that has been instilled in the population and the lack of effective prevention and treatment measures. This is where the expertise of the disaster units in the ministries of health, PAHO and WHO will be critical. A significant number of countries may overlook the potentially catastrophic impact of a pandemic because national health experts too often focus primarily on diagnosis and treatment protocols and underestimate the societal chaos that a highly virulent and infectious influenza would cause.

26. Some countries are uncertain about which national agency should lead the management of a pandemic: health, agriculture or civil protection/disaster management. This is a rhetorical dilemma, as the solution is different for each phase of the pandemic: agriculture should take the lead during the current phase 3; the primary responsibility should pass to the Ministry of Health in phase 4 and 5 when human-to-human transmission emerges, and the cross-sectoral disaster management authorities should take over in phase 6 (active pandemic).

Regional Response Mechanism

27. In 2005, the Governing Bodies (CD46.R14) requested “*the Director of PAHO to further support Member States by establishing a regionwide mechanism for immediate disaster response.*”

28. Since Hurricane David struck Dominica in 1979, PAHO/WHO has maintained a disaster response team to assess needs and respond promptly in the Caribbean. This team has been on standby every year during the hurricane season and has responded effectively. There has been no opportunity to test it after a major earthquake.

29. A regionwide response mechanism will have the same objective, namely to assist the Ministry of Health to assess damage and emergency needs in the health sector and inform the humanitarian community accordingly, provide early warning of potential public health threats, formulate public health priorities and offer guidance and advice to external health actors. In addition, the mechanism will enable WHO to carry out its UN role as lead agency and “*provider of last resort*” of assistance for the health cluster.⁹

⁹ In 2005, the Inter Agency Standing Committee (IASC) on humanitarian affairs formulated the concept of a cluster of humanitarian actors and activities to be led and coordinated by one designated agency. WHO is the lead agency of the health cluster. Direct implementation of activities as “*last resort provider of*

Constraints and Strategic Approaches

30. The response to hurricanes in smaller countries usually does not require a large number of external experts. This will not be the case, however, in large-scale disasters with an overwhelming international response involving hundreds of NGOs, bilateral civilian and military contingents and large teams from UN agencies. As a case in point, ministries of health were overwhelmed (when not marginalized) during the response to the disasters in Asia. Most responders ignored WHO's technical guidelines on issues such as field hospitals and most actors, WHO included, met with considerable difficulty when it came to mobilizing an adequate number of experts familiar with the country and the dynamics of natural disasters. In this Region, a similar experience occurred with SUMA, the humanitarian supply management system. Over the last 15 years, PAHO/WHO, with the assistance of the Foundation managing SUMA, a specialized NGO, has trained almost 3,000 SUMA volunteers for this one task, yet it is still a challenge to mobilize a regional team of 15-20 volunteers on short notice.

31. The response to large-scale disasters in the Region requires a two-stage strategic approach:

- (a) A PAHO/WHO health disaster response team composed of staff members, consultants, advisors, and personnel seconded from donor agencies¹⁰. Under this first stage, PAHO/WHO would deal with individual experts.
- (b) An intercountry mechanism that mobilize the generous solidarity from neighboring countries and from the Region as a whole. This stage would provide, in a coordinated manner, an important number of experts that will increase substantially the team mobilized at the first stage. To achieve this, PAHO/WHO would deal with ministries of health, Civil Protection and other key institutions primarily from the Region. This second stage will be most critical in major disasters for which a large number of human resources may be required for any single task.

Progress to Date

32. Progress has been made over the last 12 months in operational planning for the first stage. A limited number of individuals have been identified and trained and standard operating procedures are being internally circulated for review. The Organization is one

services" will be limited to those for which PAHO/WHO has a definite comparative advantage. Early warning system is a positive example, while repairing or reconstructing health facilities is not).

¹⁰ In the aftermath of major disasters in other regions, donor agencies have shown a great willingness to second key staff to UN response mechanisms, often a convenient last resort alternative, given the great difficulties to attract senior experts on short notice for several weeks or months. Developing countries from the Region were underrepresented and missed an opportunity to gain experience.

of the few institutions that does not charge program support costs to any extrabudgetary funds received for emergencies.

33. Coordination mechanisms are also in place. The PAHO Disaster Task Force, created after Hurricane Mitch, was strengthened and an Emergency Operations Center (EOC) will be equipped and set up in the Headquarters building. This EOC will link closely with the EOC established by the Ministry of Health of the affected country. It will also assist PAHO to better fulfill its coordinating function in support of the Inter-American response mechanism by being an easily accessible venue for Organization of American States (OAS) disaster coordination meetings.

34. Finally, internal restructuring is taking place within the Area of Emergency Preparedness and Disaster Relief. Operational responsibility for the regional response mechanism is being relocated from Headquarters to the PAHO/WHO Office in Panama, where an increasing number of humanitarian and UN agencies have regional headquarters (UNICEF, United Nations Office for the Coordination of Humanitarian Affairs (OCHA), the Pan American Disaster Response Unit of the IFRC, the ISDR, etc.). PAHO/HQ and WHO will increasingly be called on to play a supporting role, as the key functions of information management and coordination (situation reports, briefing of donors, website) will be carried out as close to the site of the disaster as possible.

The Next Steps

35. At the administrative level, efforts must be stepped up to facilitate the rapid recruitment of experts (insurance, travel documents, etc) and the procurement of humanitarian supplies. Appropriate changes to the WHO/PAHO Manual should also be forthcoming.

36. For disasters of great magnitude, it will be necessary to formally call on assistance from institutions in the Member States. It is proposed that Member States (particularly those in need to be better prepared themselves¹¹) assist PAHO/WHO to identify institutions that may enter into formal agreements to assume part or full responsibility for fulfilling a given task or function. As these tasks and functions require health skills as well as general support (information technology and management, communications, logistics, etc.), national institutions outside the health sector might also provide valuable assistance. This assistance will vary with the magnitude of the disaster.

37. Proceeding further in this direction formal endorsement from the Governing Bodies will be required. Without a strong political commitment from the Member States

¹¹ A collateral but extremely important benefit for Latin American and Caribbean countries is the preparedness value of the training to be provided to the Health Disaster Response Team and of the experience gained during the response.

and flexible administrative procedures, a truly regionwide mechanism is unlikely to succeed.

Funding of the Regional Response Mechanism

38. Preparing for the regional response mechanism and boosting the surge capacity of the Organization will be a preparedness activity funded by regular or extrabudgetary programs. A response to emergencies cannot wait for funds to be mobilized; it must begin immediately after a disaster. When technical regional support is required, speed is essential.

39. The following regional sources of funds will be required:

- (a) Advances from the PAHO Emergency Disaster Fund (PD) established in 1976 to mobilize the response mechanism without delay: The PD Fund is only to advance cash according to pledges of donors. Over the last decade, the average annual cost of relief activities has been slightly above US\$3.5 million. The last biennium relief activities reached \$11.3 million. The PD fund, the unique source for immediate funding, has been capitalized with \$400,000 within the first years of its creation. That PD fund has allowed immediate response, but in view of the increasing size of operation it is still insufficient to start all necessary field response actions to assist Member States. Thirty years later, it is now recommended to increase the PD Fund in the amount \$1 million by seeking internal or external sources of funding.
- (b) In-kind support from the Member States: this could be accomplished by covering the cost of the personnel they make available to the regional response mechanism. The endorsement of the Governing Bodies is respectfully requested.
- (c) Extra-budgetary funds provided by the international community to reimburse.

Sustainability of the PAHO/WHO Effort

40. For decades, the results achieved at the regional level have been made possible by generous extra-budgetary contributions from many governments. However, this situation is precarious. In line with the recommendation that Member States increase their financial commitment to their *own* programs, the core regional activities for this essential public health function increasingly will be integrated into the Organization's regular budget.

Action by the Directing Council

41. The Directing Council is requested:
- (a) To note the present report on the progress of national and regional health disaster preparedness and response.
 - (b) To urge Member States to support the PAHO/WHO regional health response mechanism by making human and financial resources available; to systematically and regularly gather data using standardized formats that will permit monitoring progress in disaster preparedness and risk reduction at the national and regional levels; and to provide financial support, as specified in the progress report, to increase the PAHO/WHO Emergency Fund.

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