CHAPTER 13.
INTERNATIONAL HUMANITARIAN ASSISTANCE

All countries must strive toward national self-reliance in disaster relief. However, whatever a given country's size and level of development, there are instances when international assistance is needed to provide resources or skills that are not available locally. When disaster strikes, many agencies, associations, groups, and governments offer humanitarian assistance to countries affected by natural disasters. Each has different objectives, expertise, and resources to offer, and several hundred may become involved in any single major disaster. If properly coordinated, international humanitarian assistance is beneficial to disaster victims; if uncoordinated, the resulting chaos and confusion will cause a "second disaster."

Governments must be prepared in advance to assume responsibility for the *coordination* of humanitarian assistance, as this task can hardly be improvised effectively after a disaster. *Operational control* or monopoly by civilian or military institutions is no longer feasible, acceptable, or in the interest of victims. One essential step is to designate a senior health official—the Health Disaster Coordinator—to serve as the focal point for emergency preparedness prior to the disaster, and as the coordinator of health-related humanitarian activities in the aftermath of the disaster. Dissociating the functions of preparedness from those of response is counterproductive, as they are intertwined and mutually dependent.

HUMANITARIAN AGENCIES

Agencies providing outside humanitarian assistance in emergencies fall into several categories—foreign governments, international organizations, and nongovernmental organizations (NGOs) (see Annex IV).

Government Agencies

Latin American and Caribbean countries more frequently find themselves functioning as providers of humanitarian assistance than as aid recipients. In case of disasters, there often is a spontaneous show of solidarity among countries that share similar cultures and vulnerability to hazards.

Being an effective donor rather than contributing to the confusion through technically or operationally unsound initiatives should be a political priority in every country. In the Americas, the ministers of health adopted a regional policy for this purpose (see Annex III). The minimal criteria are to avoid common unsolicited

donations (food, clothing, etc.) and to consult both with the affected country's ministry of health and with PAHO/WHO.

Many developed countries also offer generous bilateral assistance to disaster affected countries. Special departments or humanitarian assistance offices have been established in most donor countries. Among the most important bilateral or multilateral agencies active in the Americas are the Office of U.S. Foreign Disaster Assistance of the U.S. Agency for International Development (OFDA/USAID), which directs a comprehensive disaster mitigation, preparedness, and response program; the Office for International Humanitarian Affairs of the Canadian International Development Agency (IHA/CIDA); the United Kingdom's Department for International Development (DFID); and the European Commission Humanitarian Office (ECHO), whose budget and programs are the most significant worldwide. Other European countries and Japan have traditionally provided generous bilateral humanitarian assistance to Latin America and the Caribbean.

International Organizations

United Nations Agencies

The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) is responsible for alerting the international community and coordinating international humanitarian response following all types of disasters. In addition to its coordination function, OCHA can also field a United Nations Disaster Assessment and Coordination (UNDAC) team to assist in the general assessment of needs and on-site coordination during the initial relief phase. In the Americas, a regional UNDAC team consists of qualified and specially trained nationals from PAHO Member States. This team coordinates its operations closely with the PAHO/WHO disaster team, which is activated immediately following disasters. OCHA also coordinates the dispatch of search and rescue (SAR) teams from different countries in the case of major earthquakes that affect urban areas, in order to avoid common duplications and gaps in rescue activities. Finally, OCHA coordinates the occasional multilateral deployment of military assets from a number of cooperating countries. A Military and Civil Defense Unit (MCDU) in OCHA is the focal point for civil-military cooperation, with special emphasis on the use of military assets for U.N.-led operations.

OCHA's mandate is limited to humanitarian *response*. Overall responsibility for *preparedness and mitigation* in the U.N. system has been assigned to the United Nations Development Program (UNDP), as part of the approach of integrating disaster management into the development process.

At the country level, the U.N. Disaster Management Team (DMT) is made up of representatives of all agencies of the U.N. system, including PAHO/WHO in the Americas. This team is chaired by the U.N. coordinator in the country, who is usually the UNDP Resident Representative. In some countries, the DMT also includes representatives from donor governments and NGOs. The DMT aims to offer a coordinated, multisectoral approach and collaboration to the authorities of the affected country.

In health aspects of emergencies and humanitarian assistance in the Americas, the Pan American Health Organization is the focal point and coordinator for the U.N. and inter-American systems. Its priority, however, is not to substitute local

resources or to provide external material assistance but to strengthen the capacity of the countries—through preparedness and training—to respond themselves to health emergencies or disasters. In case of disaster, PAHO/WHO will provide technical cooperation in assessing health needs, formulating priorities for external health assistance, and coordinating external medical and public health external response. Although PAHO/WHO is a technical cooperation agency, it may directly provide humanitarian supplies, administer public health projects or initiatives, and offer other operational services when *no* other agency is in a position to do so. Among the technical services routinely offered is the mobilization of the expertise and capacity for management of humanitarian supplies (see Chapter 12 and Annex II for a description of SUMA, the supply management project).

Regional and Subregional Organizations in the Americas

Several subregional disaster organizations have been established during the 1990s. Decentralization from a global to a regional level is placing disaster management closer to the countries. Cooperation between neighboring countries is far preferable to the traditional international approach.

The Organization of American States (OAS) is a regional organization that lends support to its Member States in assessing their vulnerability to natural hazards and mitigating effects of disasters. FONDEM (Emergency Fund) is a mechanism established within the inter-American system for the coordination of humanitarian response among the permanent missions to the OAS, the OAS Secretariat, PAHO/WHO, the Inter-American Development Bank (IDB), and other organizations headquartered in Washington, D.C. The OAS Secretariat also offers technical assistance in risk assessment for development planning and project formulation and for reduction of vulnerability to hazards.

Following Caribbean hurricane experiences during the past few decades, and the conclusion of the Pan Caribbean Disaster Preparedness and Prevention Project in 1991, the Caribbean Governments recognized the need for a permanent regional mechanism to coordinate regional disaster management activities. The Caribbean Disaster Emergency Response Agency (CDERA) was established in 1991 by an agreement of the heads of government of the Caribbean Community (CARICOM). CDERA has 16 participating states and its headquarters are located in Barbados, West Indies. CDERA's main function is to coordinate response to any disaster affecting participating states, and to work with countries to strengthen their disaster management capacity.

In Central America, the impetus towards integration among countries resulted in the creation of the System for Central American Integration (SICA) in 1991. In their meeting in 1994, the Presidents of Central America agreed to convert the Center for Coordination for the Prevention of Natural Disasters in Central America (CEPREDENAC) into an official organization within SICA, with its headquarters in Panama. CEPREDENAC has worked since 1988 to build the capacity of scientific institutions in reducing vulnerability to disasters. The Central American Member Governments have given it the task of promoting disaster reduction in the region through an exchange of information, the development of common approaches to problem analysis, and the establishment of regional strategies to reduce disaster vulnerability.

In the Andean countries, regional cooperation regarding health issues was formalized in the Hipólito Unanue Agreement, signed in 1971. Strategies to reduce the impact of disasters on the health sector is a focus of annual meetings of the Ministers of Health of participating countries.

Nongovernmental Organizations

Worldwide, several thousand nongovernmental organizations (NGOs) are wholly or partly concerned with international humanitarian assistance, human rights, or health, and provide material, expertise, or, in some instances, cash. There are several NGO associations at the international level (see Annex IV):

- The International Council of Voluntary Agencies (ICVA), based in Geneva;
- InterAction, a Washington-based consortium of NGOs in the United States that strives to set minimum standards and promote best practices in humanitarian assistance;
- The Steering Committee for Humanitarian Response, a long-standing and influential Geneva-based working party among the International Federation for Red Cross and Red Crescent Societies, CARE International, Caritas Internationalis, Catholic Relief Services, Lutheran World Federation, Médecins Sans Frontières International, OXFAM, and the World Council of Churches;
- Voluntary Organizations in Cooperation in Emergencies (VOICE), a consortium of European agencies working in emergencies—based in Brussels, it represents European agencies before ECHO.

Many of these agencies are supported by contributions from the general public, although they increasingly receive and depend on government financing.

Nongovernmental organizations vary considerably in their approaches to humanitarian assistance and the health contributions they can make. Larger, experienced agencies and those already engaged in development work in the affected country tend to have a better understanding of the nature of the problems encountered. They engage in disaster relief only when needs have been identified. Among the most experienced agencies, national Red Cross societies and the International Federation of Red Cross and Red Crescent Societies in Geneva have been most active in disaster relief. Médecins Sans Frontières also has established a solid reputation for competent and effective public health response.

Agencies without a prior commitment to the country concerned generally have less knowledge of local problems and sometimes harbor misconceptions about the needs created by a disaster. They can thus increase the pressure on the local government by demanding operational support (for example, transportation) that would be better allocated to another agency.

In addition, "ad hoc agencies"—those formally or informally established by well intentioned but inexperienced persons in response to a particular disaster—can be a major drain on the operational resources and patience of the government of an affected country. They are generally the main source of unsolicited and unusable donations clogging the logistical chain.

Operationally, NGOs are generally more flexible and regarded as more directly responsive to people's needs than larger U.N. agencies. For this and other reasons,

donor countries increasingly prefer to channel their material assistance and financial support through their national NGOs, rather than through multilateral agencies. The health services of the disaster-affected countries should recognize and adjust to this trend.

THE ARMED FORCES

National or foreign military forces are bound to play an increasing role in humanitarian assistance in Latin America and the Caribbean. National forces of the affected country—whether directly or through the civil defense system—assume a major responsibility for logistics (transport and communication) in relief operations. Aerial surveys are often made possible thanks to the local air force. The armed forces' role is essential and should be discussed and planned for before the occurrence of an emergency. Such resources should assist and not displace other traditional humanitarian players. In particular, the ministry of health should maintain its leadership and technical authority by directing what has to be done, how it should be done, and where in all health-related issues.

In a major disaster, the assistance of foreign military forces from Western countries will be offered and likely accepted. Although these forces increasingly attempt to conduct a dialogue with major humanitarian organizations, the cultural gap between the largest and most organized forces and the civilian organizations is significant and has traditionally resulted in misunderstandings and counterproductive missions. Civilian/military structures established for emergency operations tend to supplant the long-established coordination and command mechanisms that are in place in the disaster-affected countries.

The most effective way to preserve the national health authority when there is external intervention and the coordinating role of PAHO/WHO is through continuous dialogue and participation in periodic meetings or exercises organized regionally. Ignoring the issue will not improve coordination in the next disaster.

OBTAINING INTERNATIONAL DISASTER RELIEF

Most major agencies (donor governments, NGOs) have local offices to which inquiries and requests for assistance should be directed. Requests should be formulated as soon as possible after the disaster and directed to the appropriate agency. The appropriateness of an agency for meeting a specific request will depend on its resources, communication channels, and constraints.

Resources

Agencies can make cash grants, donate supplies, provide technical assistance, furnish food, or make loans. Some specialize in only one of these areas, while others have a more general mandate. It is essential to understand how each agency functions, in order to avoid requesting cash from an agency that provides only in-kind assistance, or supplies from an agency that specializes in technical cooperation. For example, PAHO/WHO, as a specialized technical agency, provides technical expertise and cooperation rather than cash or material assistance. Financial

institutions (such as the Inter-American Development Bank, Caribbean Development Bank, Corporación Andina de Fomento) principally consider loans or small grants for development and reconstruction. They will, as a matter of policy, steer clear from emergency assistance of a humanitarian nature. The World Bank has established the Disaster Management Facility to provide a more strategic and rapid response to emergencies, and to promote the inclusion of risk analysis and disaster prevention mechanisms in all World Bank operations and country assistance projects.

Communication Channels

Proper communication channels are important, because some agencies may only accept requests for assistance from one specific source within the affected country, or will only disseminate assistance through a specific agency or ministry in a country. For example, PAHO/WHO accepts requests for assistance from health ministries, while the IFRCS distributes its aid exclusively through its national members, the national Red Cross Societies. However, despite these preferential channels, the ministry of health, through its Health Disaster Coordinator, should remain the ultimate public health authority in the affected country, and must be informed of and monitor the type and quantity of health assistance arriving in the country.

The ministry of health's coordinating role in managing donations has been facilitated by the adoption of SUMA, a standardized methodology for sorting, classifying, and inventorying incoming humanitarian supplies (see Chapter 12).

Decentralization of decision-making from donor agency headquarters to country offices has both facilitated the immediate on-site approval of small relief grants (generally under US$ 50,000), but has also complicated the processing of larger requests, which have to be reviewed by an increasing number of administrative levels.

Constraints

Donor agencies frequently operate within constitutional or statutory limits imposed on their activities. Some require the declaration of a state of emergency by the affected country or their own representative or a formal request from the government before they can respond. A request made to the U.N. OCHA is regarded as a request to the entire U.N. system. Most agencies must account for their programs and expenditures to a supervisory political body or public overseers, thus making projects with high visibility and humanitarian appeal (for instance, search and rescue) easier to fund than low-profile projects, such as sanitation measures.

Agencies may require first-hand or conclusive evidence of the need for relief before making expenditures or conducting fund raising, so the health ministry should arrange for agency representatives to visit disaster sites. Donors are increasingly better informed through their local experts, NGOs, or others of the validity of needs, and are less likely to blindly accept official information. For instance, blaming the natural disaster for long-standing development problems and requesting emergency humanitarian funds for their solutions is detrimental. The most valuable asset for a country and an international organization such as PAHO/WHO is its technical credibility.

Domestic public pressure will stimulate some foreign governments and agencies to commit funds or pledge support for specific projects or areas in the early stage of an emergency. This may occur prematurely, and before a thorough assessment of health sector priorities has even been initiated. The actual delivery of supplies or services may take considerably longer. The health sector must, therefore, prepare and submit preliminary cost estimates for short-term emergency humanitarian assistance needs as soon as possible before all emergency funds available are committed by donors. These estimates of immediate humanitarian needs are distinct from the estimated cost of the disaster to the health sector. These immediate humanitarian needs are, of course, much more modest in amount and must be met within the first days. Presenting to the donor community the total or conglomerate cost of the health impact (immediate needs, reconstruction cost, and indirect economic impact) is confusing, as humanitarian donors—by statute—must refrain from development or reconstruction activities.

A final constraint on some agencies is time, as their ability to respond quickly to a request for assistance varies greatly. Delays between the identification of needs by the affected country and the actual arrival of assistance from the outside are thus unavoidable and sometimes prolonged, resulting in assistance that arrives after needs have been met. Future emergency needs must therefore be anticipated in time for the external assistance to arrive: Request *today* for *tomorrow's* emergency needs (see Figure 13.1). PAHO/WHO traditionally collaborates with the countries in this task.

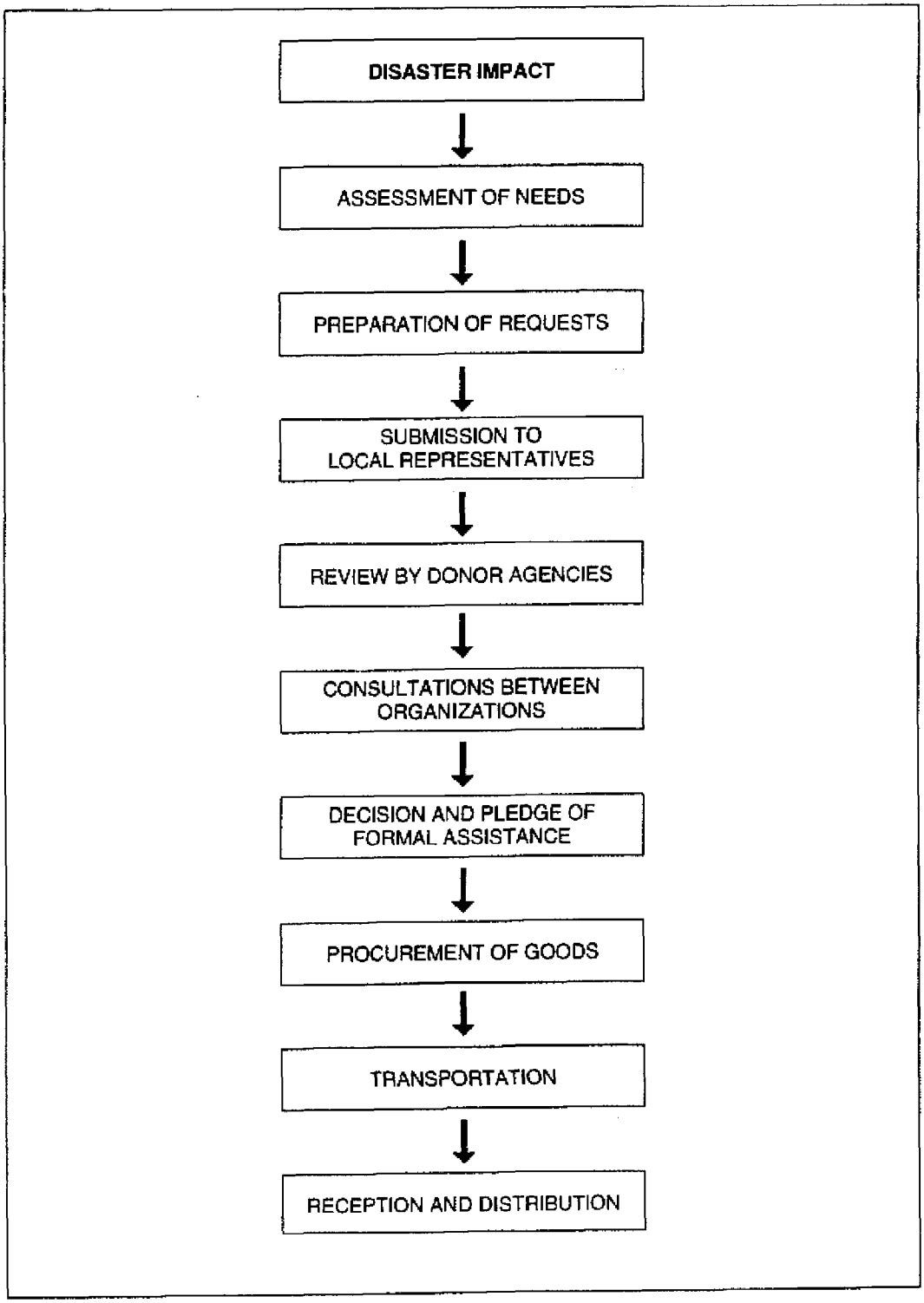
The decentralized nature of decision-making in donor countries also contributes to a longer approval process. Consensus should be reached between the local representative in the affected country and headquarters at home before any funding is allocated. E-mail and other electronic communication should be used more frequently to reduce delays. Access to and use of the Internet is fast becoming a necessity before and during emergency situations.

COORDINATING INTERNATIONAL HUMANITARIAN ASSISTANCE

The affected country must make clear administrative arrangements to communicate with, coordinate, and supervise the work of governmental and nongovernmental organizations. This can best be accomplished in regular meetings with representatives from all major bilateral or international agencies. The U.N. Coordinator, and in health matters, PAHO/WHO, may assist in programming these meetings and, if appropriate, offer a neutral hosting facility. In addition, donor agencies should each have a permanent liaison with the national emergency committee, thus enabling them to present problems to the committee as they arise.

As noted in Chapter 12, the government must clearly state that emergency health supplies and personnel should not be sent unless specifically requested (see Annex III). Informing donors of what is *not* wanted or needed is as critical as giving specifications for requirements. This statement should be circulated to all potential suppliers of assistance and diplomatic and consular representatives abroad. Adopting and periodically updating guidelines and procedures for diplomatic personnel abroad will prevent ineffective blanket appeals that lead to a flow of inappropriate donations.

FIGURE 13.1. Sequence of events that could potentially delay the arrival of requested supplies after a disaster.



However, even when the country has clearly spelled out what is or is not required, the arrival of unsolicited medical assistance, particularly in the form of drug donations or volunteer physicians or other health personnel, may be a persistent problem. On the one hand, self-supporting teams from neighboring countries or regions that share a common culture and language can provide valuable assistance. On the other, individual foreign volunteers who are unfamiliar with local conditions, unaffiliated with a recognized agency, or in some instances, have unconfirmed academic credentials, have been most counterproductive.

The simplest but at times impractical way of dealing with this problem may be for the affected country to deny admission to any medical volunteers who arrive without institutional accreditation and support. As a corollary, if foreign medical graduates and other health workers are allowed to work in the affected country after a disaster, provisions will have to be made for temporary registration or licensing requirements to be waived and malpractice insurance, if required, will have to either be provided or waived.

Bilateral mutual assistance agreements between neighboring countries or within the framework of political integration at the subregional level offer an important opportunity for horizontal cooperation, leading to collective self-reliance in Latin America and the Caribbean. Especially in disasters affecting border areas, formal agreements and joint planning and exercises are essential to removing many of the common obstacles to a prompt and effective response.

In summary, a key to the coordination of the international response is open sharing of information. Transparency is always in the best interest of the health services and the affected country. Shortcomings and even disorganization or some degree of chaos are inherent in any disaster situation, even in the most developed country. Any attempt to hide shortcomings will only stimulate the curiosity of the international mass media and will undermine the international community's confidence in the official assessment of needs. Old models of centralized information are becoming obsolete and unsustainable in a democratic environment. Donor briefings should be organized by the health sector in consultation with civil protection and foreign affairs authorities.

Public information policy should not be restricted to providing official "statements" but should encourage NGOs and other partners to openly share their post-disaster observations through, for instance, an electronic discussion group or World Wide Web site. This exchange should not require prior "validation" or clearance by the authorities.

CHAPTER 14.
REESTABLISHING NORMAL HEALTH PROGRAMS

In the first weeks after a disaster, the pattern of health needs will change rapidly, moving from casualty treatment to more routine primary health care. Services must be reorganized and restructured, often because permanent facilities were severely damaged in terms of their infrastructure and vital systems, and severe financial constraints impede rapid reconstruction. Priorities also will shift from health care toward environmental health measures during the rehabilitation phase.

The Health Disaster Coordinator will be faced with decisions in three main areas that must not be overlooked during emergency operations: identifying and addressing long-term problems caused by the disaster; reestablishing normal health services; and assessing, repairing, and reconstructing damaged systems and buildings.

LONG-TERM HEALTH EFFECTS CAUSED BY DISASTERS

Extended Need for Medical Care

If large numbers of casualties have resulted from the disaster, a small proportion (probably less than 1%) will require long-term nursing at home, institutional care, or specialized rehabilitation for months or years. Examples are paraplegics, patients with severe brain damage, amputees, and patients with chronic sepsis. In countries where specialized services for long-term care and rehabilitation are limited, this will put a strain on the health services.

Funding long-term rehabilitation programs with international resources may prove difficult, since many organizations do not have funds for such expenditures. Preliminary statistics on the numbers of patients involved, and estimates of cost should be obtained as soon as possible and made available to both national decision makers and interested international agencies.

Surveillance of Communicable Diseases

As the weeks pass after a disaster, the public is likely to become progressively less concerned about the risk of epidemic diseases in the affected region, or the reemergence of diseases such as tuberculosis or malaria. Disease surveillance remains important and should be continued until normal disease reporting systems can be restored.

Care of Displaced Populations

A major disaster with high mortality leaves a substantial displaced population, among whom are those requiring extensive medical treatment and orphaned children. When it is not possible to locate relatives who can provide care, orphans may become the responsibility of health and social agencies. Assistance should be sought from national Red Cross societies who have considerable experience in identifying orphaned children.

Efforts should be made to reintegrate disaster survivors into society as quickly as possible through institutional programs coordinated by ministries of health and social welfare, education, and work, and family welfare institutions. Special needs of the disaster survivors should be addressed when making proposals for rehabilitation and reconstruction projects presented to international financial institutions, international agencies, and nongovernmental organizations.

REESTABLISHING NORMAL HEALTH SERVICES

Two problems may occur in restoring health services to the level existing before the disaster. In some cases, resources budgeted for six months or a year are depleted in a few days of emergency relief operations, and in disasters attracting massive voluntary or international assistance, the emergency level of services or care may temporarily exceed what the country can normally afford.

The Health Disaster Coordinator should keep in mind anticipated rehabilitation needs when formulating requests for assistance, considering requirements for the affected region before the occurrence of the disaster and the short-term needs of the affected population. In most cases, outside assistance will not exceed 10% of the total requirements, and most needs will have to be satisfied locally. Accepting certain types of assistance, such as equipment, medicines, and voluntary personnel, should also be decided in terms of long-term needs.

The rehabilitation period provides an excellent opportunity for making major changes in health care delivery, since during this phase decision-makers are receptive to new ideas. For instance, clinical laboratory services, epidemiologic surveillance, oral rehydration for diarrhea patients, expanded immunization, and maternal and child health programs have been strengthened as an indirect result of floods in the Region of the Americas.

ASSESSMENT, REPAIR, AND RECONSTRUCTION OF DAMAGED FACILITIES AND LIFELINES

When water supply and sewerage systems, hospitals, and other health facilities have been damaged, the engineering sector must arrange for an immediate survey to determine damage and functionality of the facilities, including cost estimates for repair or reconstruction of the damaged facilities and systems. Existing hazards and risks should be considered when carrying out damage assessments, so that appropriate mitigation measures can be applied when repairs and reconstruction are carried out, thus avoiding damage in future disasters.

If international assistance is required for reconstruction, project plans should be as accurate and detailed as possible, including vulnerability analysis studies, and be submitted as soon as possible, since this will increase the likelihood of obtaining funds.