THE ROLE OF WHO IN DISASTER MANAGEMENT

Relief, Rehabilitation and Reconstruction

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with a contribution from

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EXECUTIVE SUMMARY

WHO's post-disaster response should cover the relief phase (immediate response), the rehabilitation phase and the reconstruction phase (development).

The role of WHO will depend on the vulnerability of the country. Countries that are highly vulnerable to disasters will rely much more on WHO in disaster management. WHO's role also will depend on the type of disaster. Sudden-impact disasters such as earthquakes or volcanic eruptions pose a different challenge to WHO than a famine or a refugee situation.

WHO is far from being the sole or principal actor in the post-disaster phase. However, through its mandate, expertise and special relationship with the health sector of the affected country, WHO is the agency that is best equipped to provide leadership in the health sector. The objectives of WHO should be to technically support the national response and guide the international response toward genuine health needs.

In the immediate relief phase, cooperation should be in the form of providing high-level expertise to diagnose the health impact, assess needs, disseminate comments, and provide general crisis management advice, rather than the traditional handing out of relief supplies.

The challenge will be particularly difficult to meet in the aftermath of sudden-impact disasters (natural or technological) when there is no time to wait for bureaucratic procedures or utilize a trial-and-error approach. In refugee and conflict situations, WHO should transcend the political implications to the extent possible. In all the above situations, the credibility of the Organization will depend upon highly competent, objective and unbiased expertise.

Once the emergency phase has passed, WHO's responsibility will consist in leading the country toward early rehabilitation and rapid reconstruction, mobilizing resources for (re)development of the health services, and taking advantage of opportunities for improvement or reforms. Relief and reconstruction should be handled by different units or mechanisms.

To achieve this objective, WHO should invest in training its own staff, changing their attitudes vis-a-vis disaster activities, and strengthening and specializing its Collaborating Centers, particularly in developing countries.

The success of these activities will depend on the investment WHO makes, prior to the disaster, in preparedness and training of the Ministry of Health and its own staff.

Simultaneously with the development of real leadership in this field, WHO should assert its mandate by negotiating or revising of Memoranda of Understanding or agreements with other UN agencies.

Mobilization of resources will be essential. The IDNDR provides a golden opportunity for WHO/ERO to develop direct contacts with the specialized humanitarian assistance office in most funding agencies. This liaison between ERO and the donors should be closely coordinated with other WHO resource mobilization initiatives.

1.1 Disaster Vulnerability: the Needs of Member States

As indicated in the document on prevention, preparedness and training, each Member State of WHO has a different vulnerability to disasters. Their vulnerability is determined the compound result of the magnitude of the hazard (risk factor), the human and material resources available in the country and the level of the national prevention and preparedness program, which varies from country to country. Therefore, the needs of each Member State will also vary considerably. WHO's potential contribution and its role in disaster response will differ according to the circumstances.

1.1.1 *Level of development*

The health assistance needs of countries with limited resources, such as the least developed countries (LCDs), will differ in nature and amount from those of more sophisticated developing countries such as India, Mexico and Brazil. At the other end of the spectrum, highly industrialized countries are less likely to require or request comprehensive technical cooperation from WHO.

WHO's emergency response should be adapted to the actual needs of the country. This response can range from playing a major operational role in disaster health management in smaller states and LDCs, whose operational capacity may be overwhelmed by the impact, to playing a discrete, standby or observer role in more developed countries.

1.1.2 *Type of disaster*

Even if the same level of health development exists, WHO's emergency response to a disaster situation in its Member States. WHO's operational contribution will obviously be significantly distinct in the aftermath of an earthquake, a civil conflict or a drought. For this reason, several types of emergency situations caused by disasters may be considered:

- **sudden-impact natural disasters** such as earthquakes, hurricanes, cyclones, floods, volcanic eruptions and incidents such as the Nyos Lake tragedy in Cameroon, where health and medical needs are immediate but short-lived. There is no opportunity for trial and error, and mistakes or delays in WHO's relief response cannot be rectified. The acute emergency phase is over in a matter of a week or two.

- **creeping natural disasters** such as drought, where the borderline between development activities and emergency operations is difficult to distinguish. Fine tuning of international cooperation by trial and error is often the rule, as the "emergency" is long-lasting.

- **chemical/radiation disasters** in recent years have proven that they are not the exclusive "privilege" of developed countries. The external response to this type of disaster will be complicated by the need for very specialized technical expertise in addition to the general "crisis management" experience that WHO/ERO or national staff should provide. In case of accidents by ionizing radiations, the matter is further compounded by national security implications in many countries. WHO's response to technological disasters should avoid overlapping responsibilities and functions with the International Atomic Energy Agency (IAEA) in Vienna or the International Program of Chemical Safety (IPCS.) As in the case of sudden-impact disasters, WHO's response should be both prompt and appropriate, as there is little chance for corrections later. WHO/ERO should take the lead, coordinating role in preparedness and response to technological disasters.

- **conflict situations** pose delicate scenarios for most UN or international governmental agencies who may be prevented from providing cooperation when and where it is most needed. The League of Red Cross Societies and NGOs are particularly effective partners or temporary substitutes under these conditions.

- **refugees** (cross-boundary migrants who are entitled to international protection) are often the result of conflict, or creeping natural disasters and have long-lasting health consequences. However, this situation also has definite political implications that may affect the actual implementation of WHO's role. Cooperation with UNHCR and its health operating partners requires further discussion. Corrections and improvement, based on trial and error, are applicable.

- **epidemics/outbreaks of communicable diseases** the response to epidemics is a major responsibility of WHO, especially in Africa where risk is high and local resources are scarce. WHO's leadership in this area seems to be widely accepted. Within the Organization, the technical input of the Expanded Program on Immunization, the Diarrhoeal Disease Control Program and the Division of Communicable Diseases complement by the crisis management expertise and logistical support of the Division of Emergency Relief Operations. It is suggested that the matter of outbreaks not be discussed further in this document.

1.2 Requests for Health Cooperation

According to the principle of respecting the sovereignty of each Member State, external assistance in the aftermath of disasters should respond to requests formulated by the national authorities. In practice, however, considerable problems often arise: requests may be slow in coming, inappropriate and/or uncoordinated.

1.2.1 *Timing of the request:* Particularly following sudden-impact disasters, information gathering takes place in a climate of interrupted communications and wide-spread damages. In the absence of contingency planning at the country level and standing arrangements at the bi- or multilateral level, the response of WHO or the international community, often is triggered by an initial, non-specific appeal for "HELP". This leaves a considerable margin in which each external actor can make independent decisions--a mixed blessing in many

cases. Developing countries affected by major sudden-impact disasters often fail to appreciate the unbearable public pressure that relief agencies and governments face to respond visibly and at once to the tragic scenes that are broadcast on prime-time TV.

1.2.2 *Appropriateness of the requests:* As stated in the WHO manual, the Organization responds to "genuine" needs; indeed, delicate judgement must be exercised as to whether a need is genuine. Decisions are based on extensive knowledge of the health dynamics of disasters, the international response, and a familiarity with the affected country's socioeconomic and political conditions. Factors affecting appeals for technical and material cooperation are multiple:

- the syndrome known by donors as the "shopping list" is illustrative. Member States who present an unreasonably extensive list of requested supplies, at times unrelated to the nature and magnitude of the anticipated health problems, and UN agencies that indiscriminately endorse these requests, jeopardize their credibility. Occasionally, the appeal reflects an attempt to obtain free equipment or supplies for an unrelated purpose. However, more commonly, it is an emotional overestimation of the needs by health officials who are unfamiliar or unprepared to face large-scale catastrophic situations;

- apparently "reasonable" requests may also prove to be technically ill-timed. Authorities may overlook the time lag between diagnosis of the problem and the actual response of WHO or the international community (Figure 1). Perishable goods or services requested for "yesterday's" health problems arrive too late to be useful.

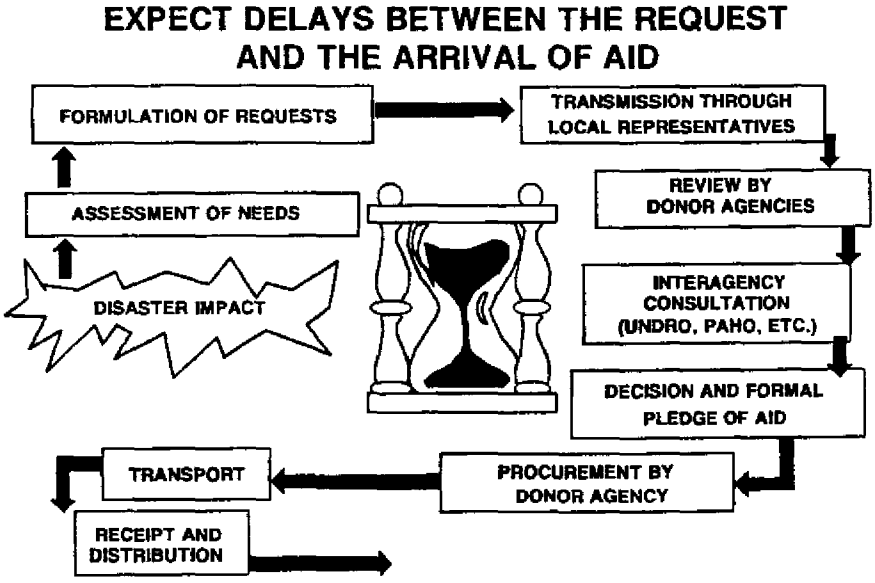

Figure 1

Search and rescue or medical teams from distant countries are an example of aid that is unlikely to arrive when it is most needed. (Figure 2);

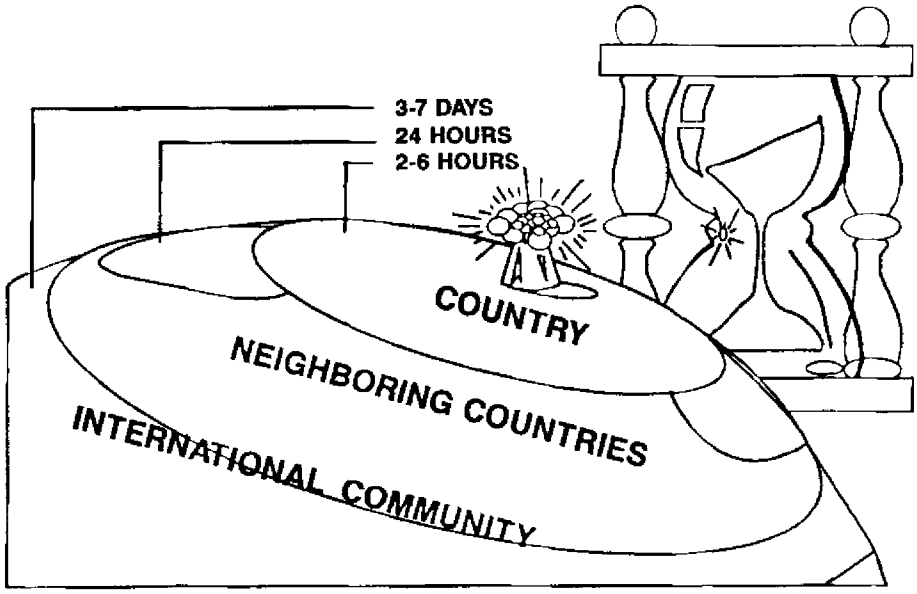

Figure 2

- in other instances, requests made in the aftermath of a sudden-impact disaster may be the result of commonly-held myths. An example is that unburied corpses will cause outbreaks of disease (Annex 1, Myths and Realities of Natural Disasters).

- many requests lack specifications. Blanket appeals[1] for medicines and food open the door to an inappropriate response. Affected countries may receive foods that are unfamiliar or incompatible with local customs, or technology that is too sophisticated to be effective in the local context.

- A lack of coordination, due to insufficient planning and preparedness at the national level, results in a multitude of formal or informal sources making appeals for health assistance: the Ministry of Public Health, Civil Defense, National Emergency Committees, Ministry of Foreign Affairs, Presidential Office, National Red Cross Society, local or international NGOs, local authorities, press interviews, ham operators, etc. The problem is compounded by the fact that often all donors receive the same, non-prioritized list of needs. As a result, the more attractive items on the list are donated in excess while other needs will remain unmet. Coordination of incoming donations is the prime responsibility of the national authorities who are often unprepared for this difficult task. In case of long-lasting disasters, a dialogue and consultative mechanisms at the international are progressively overcoming these

[1] Blanket appeals should not be confused with appeals for blankets, which is also a popular item in disaster relief !

problems. In the first highly emotional days following sudden-impact natural or technological disasters, WHO's strong and competent leadership can be critical in matching external assistance to the "genuine" health needs of the population as closely as possible.

1.3 The International Response

1.3.1 *Goals of the WHO response:*

The objectives or goals of WHO's health emergency response should be:

- to contribute to minimizing the health consequences (immediate or long-term) of the disaster;
- to support and cooperate with the health authorities in disaster management;
- to guide assistance from the international community toward the genuine health priorities of affected countries.

The regional policy unanimously adopted by all Ministries of Health of the Americas (Annex 2) is illustrative of these goals,

1.3.2 *Complementary response*

The key to an effective response is to ensure that it complements, not substitutes existing local resources. There are legitimate cases when the international community wishes it were in a position to substitute itself, to some extent, for a government that is unwilling to face its humanitarian responsibilities to part of its population. But WHO, as an inter-governmental agency, is not in position to do so. On the other hand, there have been and still are too many instances where donors are driven by domestic, political or fund-raising considerations. In these instances, they have substituted themselves, unnecessarily, for the national health authorities or services, thus imposing standards or technologies that are inappropriate *the day before* the impact and will be inaccessible *the day after* their short-lived intervention ends. This "assistance" sets back the long process of self-reliance and health development that WHO supports.

1.3.3 *International political context*

Considerations that are unrelated to the health interests of the victims often become of paramount importance in disaster situations. Full-blown emergencies are big media events and they provide considerable visibility for individuals or agencies. We often see exaggerated emphasis placed on the inadequacy of the local reaction or on the speed (rather than the effectiveness) of the international response.

In disasters that capture the attention of the media, the urge to "be seen as first at the site" threatens to turn international assistance into a self-serving race among governments and agencies. Often the mass media acts as referee. At stake is the domestic public

opinion, and this is an important factor in democracies where it influences the election of politicians or affects voluntary contributions to NGOs.

1.4 The Actors in Disaster Response

1.4.1 *The community at the local or national level*

Too often, we overlook the fact that the bulk of the response comes from the local (affected) community or the country at-large. The external assistance that arrives after natural disasters is only a minute portion of the total aid (Figure 3). In the case of conflicts and large population displacements in LDCs, the situation may be quite different in the sense that the bulk of the humanitarian assistance is provided by the international community.

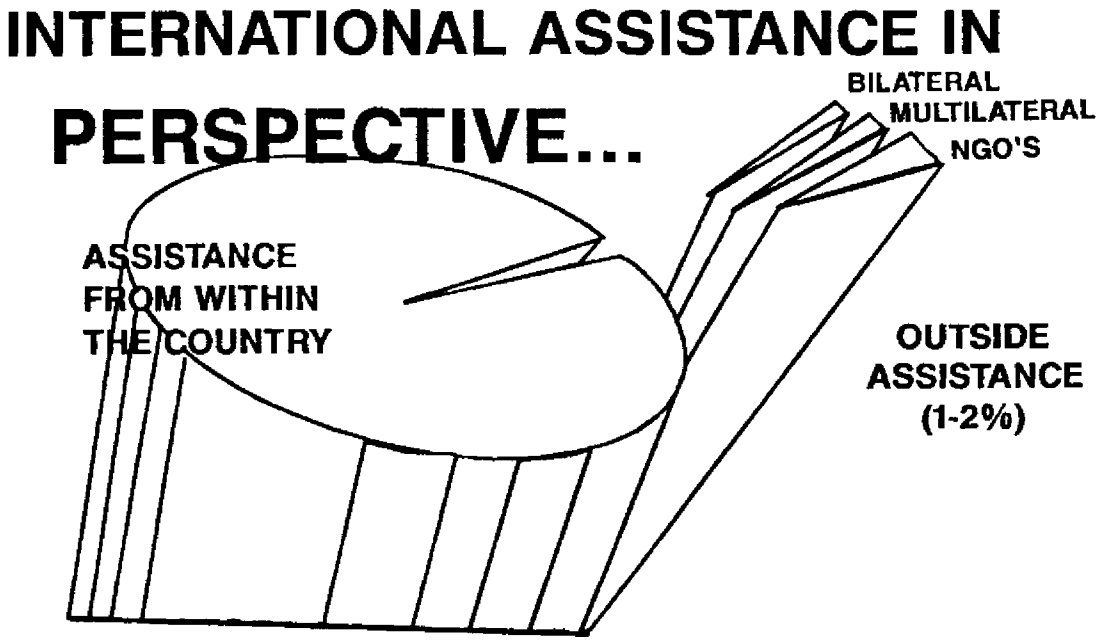

Figure 3

1.4.2 *Neighboring countries*

Populations from neighboring countries make a valuable contribution, providing direct assistance, especially when distances are short such as in the Caribbean area or by providing shelter for refugees, as in Africa. When available, this is the most appropriate form of assistance: it is culturally comptible, readily available and in the spirit of technical cooperation among developing countries TCDC.

1.4.3 *Government-to-government assistance*

Bilateral assistance remains one of the most organized and responsive sources of material assistance in all types of disasters. Traditional "donor" governments or agencies have access to direct information sources, funds, supplies, personnel and transport facilities that no UN organization can match. National interests may affect the allocation of these resources.

1.4.4 *The UN system*

In addition to WHO, several agencies or offices directly affect or provide health-related assistance. These include, among others, UNDRO/UNDP, UNHCR, UNICEF, FAO/WFP, IAEA, UNOCA, UNWRA. The main advantage of the UN system is its widespread political acceptance and its considerable experience in technical cooperation with developing Member States. The UN system has little, if any, national or financial resources of its own for this purpose. A summary of the mandates of key UN agencies is in Annex 3.

1.4.5 *The Red Cross System*

National Red Cross and Red Crescent Societies represent a powerful support to the health authorities in case of emergencies. Humanitarian assistance is indeed the (raison d'être) of the National Societies. At the international level, the League of Red Cross and Red Crescent Societies (LCRCRS) and the International Committee of Red Cross (ICRC), with headquarters in Geneva, both play a major role: LCRCRS in case of natural or technological disasters, and ICRC in cases of civil conflict. The operational capacity of both agencies, and ICRC's mandate during conflicts, compensate for the built-in limitations of WHO as a specialized UN agency. A summary of the mandates of LCRCRS and ICRC is in Annex 4.

1.4.6 *Specialized development or relief NGOs*

From large, development-oriented agencies to small, specialized relief groups, from well-known multinational organizations to local associations, private NGOs provide health services to thousands of groups or areas that are under-served by national health services. In some Member States the sheer number of these agencies or their mistrust of the central bureaucracy make coordination a tremendous challenge for the Ministry of Public Health even in normal times. In case of disasters, the contribution of NGOs with their direct and close links to their beneficiaries, fills unavoidable gaps in official relief efforts. These agencies have direct access to the public in developed, affluent countries, and thus may channel large amount of resources directly to disaster victims for relief, rehabilitation and reconstruction. These resources are otherwise unavailable to developing countries. Relief operations managed by the UN system, such as refugee camps managed by UNHCR or other UN agencies, frequently depend on their operational partnerships for the actual delivery of services.

1.4.7 *Ad-hoc groups*

Well-intentioned groups of concerned individuals who unite in a specific emergency situation or professional associations (medical associations, chambers of commerce), private corporations or others willing to offer goods or services directly to disaster victims fall under a special category of NGOs. When properly informed, these groups offer a precious and effective source of cooperation. When misguided, however, they may cause innumerable problems such as inappropriate donations, unsolicited or unprepared volunteers that burden the local authorities, etc.

1.4.8 *Commercial opportunists*

The contribution of the private sector is overwhelmingly generous and effective as evidenced by donations to the Red Cross or experienced NGOs, support to bilateral or UN efforts, direct assistance to local employees and communities, etc. But disasters also provide an opportunity for a small minority to quickly and effortlessly profit from the situation. Tax-deductible dumping of unsuitable pharmaceuticals or food products, political lobbying or inaccurate clims for expensive products such as airborne mobile surgical units offering services unsuitable for the circumstances (which subsequently divert funds away from relief and rehabilitation priorities) are common occurrences. Relief and health officials and WHO Representatives may not be fully prepared to deal with these.

1.5 WHO's Relationship with other Actors

WHO has made a remarkable effort and substantial progress in general, and Emergency Relief Operations (ERO) in particular, in establishing or strengthening a collaborating relationship with most other actors.

Within the UN family, formal memoranda of understanding have been signed by WHO with UNDRO, UNHCR and UNOCA. These agreements in Annex 5. are subject to periodic revision and updating. Similarly, letters have been exchanged with LCRCRS and ICRC (Annex 6).

Mechanisms and procedures exist to establish a formal relationship between the Organization and non-governmental organizations. NGOs of particular relevance to disaster response should be identified from the list in in Annex 7. WHO organized a consultative meeting in New York in January 1989 with 40 NGOs from the USA and Canada. Participants discussed joint health activities within the International Decade for Natural Disaster Reduction.

At the country level, working relationships have been established with organizations active in the health field. Both at headquarters and in the regional offices, focal points have been designated to liaise with NGOs on all WHO program activities.

No formal mechanism exists to promote the private sector's contribution to the health relief and rehabilitation priorities of disaster-affected countries.

2.1 WHO's Mandate in Emergencies

WHO's mandate in emergencies comes from its Constitution: Chapter II (Functions), Article 2, Item (d) states that, among its functions, the Organization is to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments. In addition, many other official functions relate to emergencies as well as to general health development. Functions pertaining to prevention, education, providing standards of care, and cooperating with other specialized agencies, for example, apply to ERO's work as well as to the work of other technical units.

Numerous resolutions of the World Health Assembly or the regional committees have strengthened and confirmed WHO's role in specific disaster situations. Subject to acceptance and request from the affected country, there are few, if any, pre-established limits to the role that WHO might theoretically play in the broad health field.

2.2 WHO's Objectives

WHO's response to catastrophic situations is an extension of its normal technical cooperation and, in particular, of its prevention and preparedness functions. Consequently, it will follow the same basic objectives:

- To promote and support the establishment or strengthening of a technical program in the Ministry of Health responsible for ongoing, pre-disaster planning and coordination of health sector relief activities in case of disasters.

- To promote and support the training of national human resources required for an effective health response in case of disasters.

- To stimulate close cooperation between the Ministry of Health, other governmental institutions, non-governmental organizations (NGOs), Civil Defense and the representatives of the international community before, during and after disasters.

- To improve health assistance from the international community to a country affected by a disaster.

As a development agency, WHO's immediate response (relief) must never lose sight of the medium and long-term health priorities established at the global level by the World Health Assembly and at the country level by the Ministries of Public Health. Humanitarian-type activities (EPR) should prepare the grounds. They should be replaced by lower profile rehabilitation and reconstruction programs (REL), as soon as it is practical.

2.3 Criteria for WHO Response

- WHO, as the UN agency responsible for health is expected to offer/provide competent and visible cooperation in the aftermath of any disaster. An effective, internal, rapid response mechanism is, therefore, not a luxury but a must.

- WHO's response should provide a creative model for the international community (leadership) rather than attempting to duplicate the activities of other agencies, ("me too" approach)

- WHO should concentrate on what it does best its role, which no one else can or should play.

- WHO should closely coordinate and integrate its activities within the UN system's response and be willing to play a coordinating role beyond the UN system.

- WHO's response should support TCDC, making use of expertise from other developing countries regionally and globally.

2.4 General Outline of WHO Strategy

2.4.1 *WHO immediate response (relief)*[2]

In almost any type of disaster (natural disasters, technological disasters, population displacements, etc.), WHO must be ready to provide immediate technical cooperation (relief). A core of basic functions will be complemented by additional activities, as circumstances dictate and resources permit.

Basic relief functions may include:

- assisting in the rapid diagnosis of the health impact and assessing objectively the outstanding immediate needs;

- disseminating authoritative comments regarding emergency health assistance requested from the international community;

- assisting in the coordination of international health assistance;

- providing technical advice on the general health management of the immediate crisis;

- procuring supplies (on a selective basis);

- acting as the global health sector memory: preserving perishable data/lessons learned.

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[2] Relief, rehabilitation and reconstruction are defined in the document "The Role of WHO in Disaster Management: Prevention, Preparedness and Training," section 1.2.3 The current use of the term *Relief* in WHO/ERO to cover long-term rehabilitation/reconstruction activities is misleading. For most of the international community, relief is limited to the immediate response.

These immediate response activities are best implemented by the WHO/ERO unit responsible for disaster preparedness. Relief response in sudden impact disasters may last as little as 8-10 days.

2.4.2 *WHO's role in rehabilitation*

The needs for external cooperation do not decrease with time. On the contrary, they increase just as the interest of the international community may be waning. To make the point, it could be stated that too much is done during relief and far too little during rehabilitation. Cooperation for rehabilitation and reconstruction must be initiated simultaneously with immediate relief. Rehabilitation may last as little as 4-6 weeks in sudden-impact disasters.

WHO is not as involved or absorbed in actual relief operations as the national health services are. Therefore, it has a unique perspective of the situation and the expertise to accelerate the shift from relief to (re)development and activate the recovery process.

Core rehabilitation functions include:

- assessment of needs for temporary restoration of normal services;
- formulation of short-term rehabilitation projects;
- dissemination of information on health priorities and mobilization of resources.

2.4.3 *WHO role in reconstruction*

During rehabilitation, temporary or provisional measures are offered for long-term problems and needs. In the reconstruction phase, permanent solutions aim to establish, rebuild or improve the health services delivery system, using normal, well-known development methods and techniques. This is also the golden time to include disaster prevention and preparedness considerations in mainstream development activities. The "disaster cycle" (Figure 4) from prevention to response to prevention is completed.

THE DISASTER CYCLE

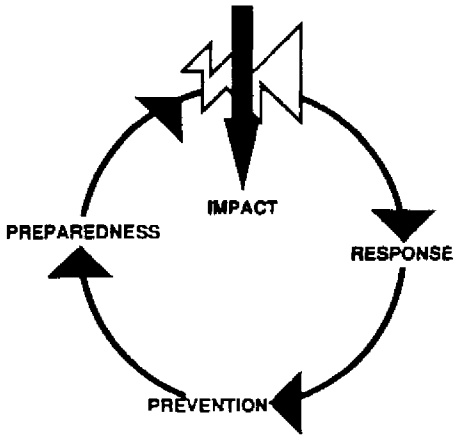

Figure 4

However, the special political context and urgency of the process, especially following conflict situations, will require extraordinary logistical support and simplified administrative procedures, a field where WHO/ERO excels.

Core reconstruction functions include:

- promoting the formulation of a master plan for reconstruction or restructuring of the health services;
- strong advocacy of the master plan health priorities into the overall reconstruction program at the UN, bilateral and national level;
- priority in mobilization of resources;
- international leadership/technical cooperation in executing the master plan.

This phase, in most disasters, lasts several years.