



**Pan American  
Health  
Organization**



*Regional Office of the  
World Health Organization*



Executive Report of the  
Consultation on Global  
Humanitarian Trends  
and their Implications on  
Institutions in the Americas

**Airlie Center, Warrenton, VA  
3-4 April 2008**



The topic of disaster management has grown steadily and gained an increasingly important place on the health agenda of countries in Latin America and the Caribbean. However, the increasing number of actors, the improved capacity at local and regional level and globalization is quickly changing how we deal with risk reduction and disaster management.

To address these realities, the Pan American Health Organization, regional office for the Americas of the World Health Organization, organized a high-level consultation on global humanitarian trends and their implications on institutions in the Americas.

Over a two-day period, from 3-4 April 2008, experts discussed some of the broad issues that are driving these changes at global level and their implications at country level.

This Consultation came at a particularly critical time, providing rich input into the Pan American Health Organization's next strategic plan (2008-2012) for a **secure and disaster resilient health sector in the Americas**.

This following document includes an **Executive Report** of the deliberations of this meeting, a **list of participants** and the revised **position paper** on global humanitarian trends and their implications for on institutions in the Americas.

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## **Executive Report of the Consultation on Global Humanitarian Trends and their Potential Implications on Countries in the Americas**

Airlie Center, Warrenton, VA ♦ 3-4 April 2008

The objectives of the meeting were to:

- Review and validate the potential implications of global humanitarian changes for national health or disaster institutions in Latin America and the Caribbean (LAC).
- Suggest possible courses of action for the Pan American Health Organization (PAHO/WHO) and other interested partners to maximize the positive impact of the global changes on the disaster management capacity of the LAC.

High level participants (listed in Annex 1) from a broad range of agencies reviewed the discussion paper (Annex 2) prepared by a group of disaster management experts and provided recommendations to PAHO/WHO on these and other issues. They shared their experience on a personal basis. The opinions expressed did not necessarily reflect those of their organizations.

### **1. Relevance of the discussion paper on Global Humanitarian Trends and their Implications on Institutions in the Americas**

There was consensus that the diagnosis made regarding changes in the humanitarian field and their potential implications on national institutions in LAC was relevant and appropriate.

In the introduction, experts suggested stressing the importance of emerging threats such as the Pandemic Influenza and climatic changes. Although addressing the challenges resulting from these changes will require additional commitment from the health sector in LAC countries, the current commitment to risk reduction and preparedness alone is still seen as insufficient.

It was perceived that the discussion paper presented a somewhat negative perception of the impact of humanitarian changes on national institutions. This should be balanced with the potential gains for beneficiaries (i.e. the victims) that result from more efficient fund raising and response.

These points have been addressed in the revised discussion paper, which is attached to this report or available on request from [disaster@paho.org](mailto:disaster@paho.org).

## **2. Changes in funding patterns**

### **a. Conclusions**

The lack of access by governments of disaster-affected countries and/or attempts to influence how aid is used are valid issues that should be addressed internationally. The root of the problem lies in the varying levels of performance of Ministries of Health when it comes to managing and accounting for external relief funds. Bilateral donors in the Region have shown openness and flexibility in channeling funding directly to national institutions that are clearly competent and transparent. The case of the Ministry of Health in Ecuador is an example of one success story.

The participants recognized the risk of marginalizing national authorities, given the current procedures for allocating CERF and other pooled funding. The evaluation of the CERF that is currently ongoing should take into consideration this point.

Ministries of Health also lack knowledge and understanding of existing funding mechanisms for humanitarian response. The Inter-American Development Bank, for instance, has significant funding for risk assessment for climate change, yet the health sector in LAC countries has not availed itself of this funding source.

An imbalance exists between funding that is available for disaster response and what is available for preparedness and risk reduction (DRR). Participants discussed at length the matter of assigning a percentage of humanitarian funding for DRR. Participants felt the allocation of relief funds for preparedness, or at least the flexibility to do so, should be encouraged, but stopped short of recommending a pre-determined percentage. It is more important to include DRR as an item in all national development budgets and projects rather than only in post-disaster external relief assistance.

Finally, it was noted that some UN agencies have a flexible pass-through mechanism to transfer funds rapidly for a nominal fee to other partners: NGOs or national institutions. WHO does not have such a procedural mechanism.

### **b. Recommendations**

The debate on funding patterns and their implications, which took place at this meeting in April 2008, should be repeated at subregional levels in Latin

America and the Caribbean and involve subregional organizations, the health sector, the Ministries of Foreign Affairs and other actors.

Development funds allocated by international financial institutions (IFIs) should be more fungible, that is, reprogrammable to areas at greatest risk or in need.

LAC countries should improve perceptions regarding their ability to manage funds by utilizing, as appropriate, the OECD Principles of Corporate Governance. PAHO/WHO should help to improve the capacity of the Ministries of Health to manage and report on humanitarian response projects.

PAHO/PED should inform and train national counterparts on the existing funding mechanisms (CERF and others) and priorities.

PAHO/WHO should develop a flexible pass-through administrative mechanism for rapidly channeling external funds to MoH and possibly NGOs.

Participants should brief the OCHA-commissioned team that is currently evaluating the CERF.

### **3. Humanitarian response vs. recovery/reconstruction**

#### **a. Conclusions**

The phases of the disaster cycle form part of a continuum. Following the impact, recovery and reconstruction must begin immediately. Increasingly, the World Bank and the Inter-American Development Bank are ready to begin the recovery process immediately following the disaster impact – concurrently with emergency response. Response actors and coordinators must take this factor into account.

Humanitarian and development actors differ on who is best equipped to lead the recovery process. The experts at this meeting see recovery as primarily a development activity rather than a humanitarian activity. However, in practice, this process is initially driven by the availability of humanitarian (response) funding and managed by humanitarian responders, who may not necessarily have the skills and development experience needed.

The health sector is one of the weak links in recovery/ reconstruction. The lack of recovery plans and shortcomings in terms of the participation of the Ministries of Health in the reconstruction process were noted.

Early recovery is the time to (re)introduce disaster risk reduction in the planning process.

**b. Recommendations**

Humanitarian actors should consider the developmental nature of recovery activities and take advice from agencies that specialize in recovery and reconstruction.

IFIs should make risk management an early component of any recovery process.

LAC countries, in particular the Ministries of Health, should discuss recovery plans prior to disasters.

**4. The Humanitarian Reform and the Cluster initiative**

**a. Conclusions**

The participants recognized the need to improve coordination of humanitarian response and the importance of the Humanitarian Reform for the beneficiaries, especially in complex disaster situations. They noted that some disaster-affected governments and experts have expressed reservations regarding a potentially negative impact on national institutions in situations where the humanitarian reform is implemented without consultation or adjustments in the most advanced of developing countries .

The Cluster mechanism is not meant to replace governments, especially in the case of sudden-onset natural disasters in advanced countries.

In the health field, donor representatives recalled the comprehensive nature of PAHO's health coordination in past disasters, in line with WHO's holistic definition of health as a state of physical, social and mental wellbeing. They also noted that, under the humanitarian reform, the lead responsibility for health is disaggregated into four distinct Clusters.

In LAC, there are definite advantages as well as precedents for consolidating the number of the health-related Clusters according to the structure and role of the Ministry of Health. As recognized by the Eastern Caribbean Donor Group, "if the national system is working, we should support it."

Finally, participants determined that the increasing use of English as the working humanitarian language in recent disasters further hampers the active involvement of local authorities from non-English speaking countries.

**b. Recommendations**

The UN should adapt its Cluster structure to the organization of the affected country, not the reverse. In LAC, a sectoral/cluster approach, consolidating all health activities into one mechanism, with the Ministry of Health as lead agency, may be more appropriate in most cases.

PAHO/WHO, in line with its mandate and past experience, should continue to provide technical guidance and coordination on all matters related to health.

LAC countries should request the humanitarian community and OCHA to adopt Spanish as the only working language for Cluster and coordination meetings in Latin America (or Spanish-speaking Caribbean countries such as the Dominican Republic and Cuba), to facilitate leadership and participation from the national institutions.

**5. A comprehensive risk reduction approach**

**a. Conclusions**

The International Strategy for Disaster Reduction (ISDR) has developed inter-agency groups and a joint program of work, with a system to track investments in disaster risk reduction. However, in most cases, the health sector is not one of the most active members of ISDR National Platforms. The Hyogo Framework of Action (HFA) is an important entry point for the LAC countries. However, LAC may not have insufficient information on the HFA and this might be the cause of a perceived lack of commitment.

Most Ministries of Health in LAC are weak when it comes to advocacy and outreach. Most often, they do not have a budget line for risk reduction. Their focus remains on response / preparedness and communicable diseases.

**b. Recommendation**

PAHO/WHO and the Ministries of Health should take advantage of the ISDR regional meeting of National Platforms in February 2009 to stimulate health sector awareness and commitment to HFA goals.

## **6. Awareness and capacity building**

### **a. Conclusions**

National authorities in LAC are not sufficiently aware of the potential benefits as well as the unintended consequences of the global humanitarian changes, including the Humanitarian Reform, International Health Regulations 2005, the CERF and other mechanisms.

If the population of LAC and its institutions are to benefit from these changes, decision makers in health, foreign affairs and other sectors must become more familiar with the issues. All participating agencies should make it a priority to keep them well informed.

Sustainable improvements in disaster risk reduction (from prevention to response and recovery) are contingent upon strong and committed institutions. Marginalizing (and thereby weakening) national institutions is counter-productive in the long run. Along the same lines, simply demonstrating commitment on the part of LAC countries is insufficient, given the magnitude of the problem.

### **b. Recommendations**

PAHO should place the highest priority on building awareness and capacity in the Ministries of Health and Foreign Affairs to understand international mechanisms and the potential benefit of their proactive use, as well as the cost of not asserting national leadership in this field. These sessions should be multisectorial and carried out with the collaboration of relevant partners.

A sustained effort to educate countries could include:

- i. A mapping of all instruments available to assist governments, not only in response but also in disaster risk reduction
- ii. A comprehensive training package on these tools
- iii. Case studies / success stories (possibly Ecuador)
- iv. A situation analysis for briefing Ministers of Health at the PAHO/WHO Directing Council Meeting (September 2008).

PAHO should target decision makers throughout the Region and in PAHO/WHO to seek additional commitment to DRR and engagement in the reform process.

PAHO should raise selected issues from the discussion paper at the next meeting of UN Regional Directors.

**7. Emerging threats: Climate change and pandemic influenza**

**a. Conclusions**

Neither the discussion paper nor the PED Strategic Plan sufficiently addresses the issue of new threats, in particular climate change.

Climactic changes are likely to impact public health and manifest themselves through an escalating number of events over time, including more severe hydrometeorological disasters, food scarcity and increased transmission of communicable diseases. Some events will have severe consequences that will activate PED's disaster management mandate and intersectoral coordination mechanisms.

There is a lack of health studies and impact assessments in LAC. IFI funding is available but not used by countries.

When it comes to pandemic influenza, a functional distribution of tasks exists within PAHO/WHO. However, this is not yet the case for climate change.

**b. Recommendations**

PAHO/PED and the ministries health should develop partnerships with agencies that conduct impact assessments related to climate change.

Ministries of health must build stronger linkages with national climate change commissions.

PAHO/WHO should clarify its internal distribution of roles and responsibilities using disaster scenarios resulting from climate change.

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Airlie Center, Warrenton, VA

3 to 4 April 2008

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**Discussion Paper on  
Global Humanitarian Trends  
and their Implications on Institutions  
in the Americas**

**Meeting of Experts  
convened by PAHO/WHO  
Airlie Center, Warrenton, VA  
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## Introduction

The countries of Latin America and the Caribbean (LAC) have long been leaders in the field of disaster preparedness and response (disaster management). In the 1980s and 1990s, unparalleled progress was made in convincing governments and agencies to take seriously the risks posed by natural disasters and to plan ahead to reduce risk and prepare to respond to the health consequences. Many countries established full-time disaster management offices and the ministries of health appointed National Health Disaster Coordinators. The collapse of Hospital Juarez in the 1985 Mexico earthquake triggered a progressive shift from preparedness and response toward a more comprehensive risk reduction approach in the health sector, which ultimately led to the adoption of “*Hospitals Safe from Disasters*” as the theme the ISDR-WHO World Disaster Reduction Campaign for 2008-2009.

Today, the situation is distinct:

- New threats, such as terrorism, SARS, pandemic influenza and climate change are becoming more prominent;
- The pace of change within the global humanitarian community has accelerated. These changes, which are partly the result of explosive growth in this sector, can also be potentially beneficial at country level. The focus of this paper is on the potential impact of these humanitarian trends and reforms—both positive and negative—on the capacity of national institutions and in particular, ministries of health;
- Institutions in LAC may not be fully aware of these global changes and consequently are slow to adjust and take maximum benefit of all they have to offer for disaster-affected populations.

Humanitarian changes at global level include:

- Increased awareness of disaster risk reduction, thanks in part to the adoption of the Hyogo Framework of Action;
- Changes in humanitarian funding patterns;
- The involvement of new actors;
- The adoption of minimum standards for humanitarian assistance;
- Overlapping between relief, recovery and reconstruction;
- Redefining disasters and emergencies: shifting priorities;
- The changing role of financial institutions;
- The revised International Health Regulations;
- The United Nations Humanitarian Reform.

It is questionable whether countries in this Region are sufficiently aware of and ready to adapt to these changes. Justifiably proud of their early pioneering efforts, the countries of LAC and their inter-country or regional disaster institutions tend to remain in isolation, fostered by a common language and culture.

## **Humanitarian changes at global level of potential importance for LAC and its inter-country institutions**

### ***Increased awareness of disaster risk reduction: the Hyogo Framework of Action (2005-2015)***

The United Nations deemed the decade of the 1990s as the International Decade for Natural Disaster Reduction. As a result, political and public awareness of the socioeconomic cost of disasters rose dramatically. It culminated with the Hyogo Framework for Action (HFA), adopted at the World Conference on Disaster Reduction (January 2005). The catastrophic impact of the tsunami in December 2004, just a few weeks before this global conference, focused world attention on prevention and preparedness.

The HFA's emphasis on sustainable development, mainstreaming of risk reduction and above all, on national responsibilities are very positive:

“each State has the primary responsibility for its own sustainable development and for taking effective measures to reduce disaster risk, including for the protection of people on its territory, infrastructure and other national assets from the impact of disasters. At the same time, in the context of increasing global interdependence, concerted international cooperation and an enabling international environment are required...”<sup>1</sup>

### ***Changes in humanitarian funding patterns***

#### **The amount of funding**

Global funding for risk reduction has undoubtedly increased as a result of the adoption of the HFA, but to a far lesser degree than funding for immediate response.

In the aftermath of the tsunami, US\$14 billion were pledged and, for the most part, delivered. Almost 40% came from private contributions to NGOs and the Red Cross system, as compared to an average of 15% in most disasters. The customary coordination mechanisms and national authorities in affected countries had minimal influence on how this funding was used.

The Tsunami Evaluation Coalition (TEC) conducted a study on the funding of the response to the tsunami in late 2004 and early 2005. Without taking into consideration funds received for disaster prevention, mitigation or risk reduction, the TEC study found that the overly generous funding had a perverse effect on the humanitarian community:

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<sup>1</sup> Hyogo Framework for Action, paragraph 13. Online at [www.unisdr.org/eng/hra/hfa.htm](http://www.unisdr.org/eng/hra/hfa.htm).

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The evaluators concluded that *“Much of the implementation response was driven by the availability of funds, or by contextual opportunism, rather than by needs.”*

Of greater relevance to LAC is the potential for a negative impact on local institutions.<sup>2</sup> In another TEC study, a different group of evaluators noted that: *“By ignoring local capacity, the role of external aid is made to seem all the more important. The more external aid there is, the more that local capacity is undermined.”*<sup>3</sup>

Although the tsunami in South Asia may be an extreme example, the response to the Pakistan earthquake followed a similar pattern of very generous short-term donations in the immediate aftermath, reflecting a definite trend in international response, especially in high-profile media events.

## **Funding mechanisms**

Mechanisms for funding humanitarian response have also evolved. With the establishment of the **Central Emergency Response Fund** in March 2006,<sup>4</sup> UN organizations, and through them international NGOs and the IFRC, now have access to large amounts of funding for life-saving activities or chronically underfunded response operations. International NGOs have suggested that they also should have direct access to CERF funding, and one suggested that 50% of CERF allocations should go to NGOs<sup>5</sup>.

Government and health authorities have no direct access to CERF, and there is no requirement that country authorities are consulted in the definition or implementation of CERF-funded projects. The ministry of health is not formally a part of the process to formulate priorities or review health proposals, despite the fact that the UN General Assembly Resolution (A/RES/60/124) approving the CERF *reaffirmed* the guiding principles of Resolution 46/182 of 19 December 1991.<sup>6</sup> Since its launch, the CERF has committed US\$ 619.1 million to humanitarian projects in 60 countries affected by natural disasters and armed conflicts.

Bilateral humanitarian funding also tends to concentrate on a few global agencies, either through direct support to those international partners or through pooled funding under

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<sup>2</sup> In most disasters, including in Latin America (Costa Rica, El Salvador, Peru) and the Caribbean the health personnel are also heavily affected by the impact.

<sup>3</sup> TEC [Impact of the tsunami response on local and national capacities](#), p. 11.

<sup>4</sup> [A/RES/60/124](#)

<sup>5</sup> OXFAM Briefing Paper 100. The UN Central Emergency Response Fund One Year On.

<sup>6</sup> Guiding principle 4: “Each State has the responsibility first and foremost to take care of the victims of natural disasters and other emergencies occurring on its territory. Hence, the affected State has the primary role in the initiation, organization, coordination, and implementation of humanitarian assistance within its territory.”

[A/RES/46/182](#)

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UN management. Based on recent PAHO/WHO experience, bilateral funding through regional/subregional partners appears to have decreased.

### **Ineligibility of MoH for humanitarian funds**

Funding partners and the public prefer to direct their increasing contributions toward NGOs, Red Cross and UN agencies for the immediate response. Government institutions, even those with good track records when it comes to transparency and disaster management, are not eligible to manage relief funds and deliver services. Donors do not sufficiently differentiate between countries with an emerging economy and considerable human resources for rapid response to a natural disaster and the so-called ‘failed states,’ where authorities lack transparency and good governance and may be part of the problem in a conflict. However, active participation on the part of the Ministries of Health may provide the necessary legitimacy; strengthening national capacity should be a key strategy of the global response system.

### ***The involvement of new actors***

With the availability of generous funding in search of a project or an implementing partner, the number of humanitarian agencies and actors is increasing dramatically. As the IFRC correctly stated, humanitarian response is now the “largest unregulated industry”.<sup>7</sup>

The involvement of many new actors can be, in itself, a positive development that reflects mainstreaming of the topic. However, it poses a difficult challenge to coordinating health authorities (and international organizations) in terms of differentiating among NGOs with skills and expertise from the growing number of amateur-like, unprofessional groups.

The NGO community is not the only “new actor” that brings potentially valuable assets and contributions to the table. The private sector, in particular the pharmaceutical or food industry, now provides direct “technical assistance” and support, occasionally under the banner of the UN. However, there is little, if any, interaction with national authorities, including the Ministries of Health. A lack of coordination with and guidance from the Ministry of Health only contributes to a further blurring of the lines between non-profit and for-profit undertakings in the aftermath of disasters. On the one hand, the pharmaceutical or information industries have much to contribute in terms of knowledge, skills and material donations. On the other hand, there is always a question of conflict of interest when commercial proprietary products (software, drugs or vaccines) are promoted and introduced by “humanitarian actors” with little oversight from the Ministries of Health and UN technical agencies.

Foreign militaries in LAC have always been a major actor in international response. Now the trend is gaining strength globally, at times making this institution the dominant player,

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<sup>7</sup> World Disaster Report, International Federation of Red Cross and Red Crescent Societies, 2004

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at the expense of traditional mechanisms and the health sector's coordination role (Ministry of Health).

Government-sponsored Civil Brigades may offer very effective and appropriate assistance (medical or other), provided they respond to actual needs and adjust to the socio-political context of the affected country.

In the UN system, specialized inter-agency mechanisms or services have been established or strengthened: from the well established UNDAC,<sup>8</sup> to the Humanitarian Information Center (HIC) and the UN Joint Logistic Center (UNJLC), which are lesser well known in LAC. These mechanisms, when mobilized, assume *de facto*, the leadership in their respective areas. This situation was observed in Indonesia, Sri Lanka and Pakistan, as well as in the recent floods in Bolivia.<sup>9</sup> Although local authorities are often unprepared to claim their coordinating role, substituting them with relatively well- equipped and focused mechanisms, which have been endorsed by the donor community, may turn out to be counterproductive.

### ***The adoption of minimum standards for humanitarian assistance***

Humanitarian assistance must follow some principles and apply some kind of measurable standards for accountability and quality control. For this purpose, the SPHERE Project was launched in 1997 by a group of humanitarian NGOs and the Red Cross and Red Crescent movement. The principle and widely-used SPHERE product is a handbook detailing Minimum Standards in Disaster Response (health, water, shelter, etc) that people affected by disasters have a right to expect from humanitarian assistance.<sup>10</sup>

Although the formulation of universal standards is an achievement, these “minimum” standards are unrealistically high. For instance, 15 liters of quality drinking water/person/day in many poor rural areas may be far above what was available prior the disaster or could be sustained. In the medical care field, staffing guidelines are also rarely attained under non-emergency circumstances in developing countries.<sup>11</sup> The result is the temporary and costly

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<sup>8</sup> The participation of experts from the Americas in the UNDAC mechanism is a model for other regions.

<sup>9</sup> In January 2006, the Bolivian highlands experienced intense, prolonged rainfall. Thousands of families were affected. Although a general lack of leadership was observed among national institutions responsible for emergency management, the situation was aggravated when the UN established an external structure, headed by the UNDP. This group, known as UNETE (United Nations Emergency Team), was designed to convene and coordinate UN agencies that have a country presence. The fact that UNETE assumed a role well beyond coordination resulted in the “drawing back” of national institutions. This situation at the national level was repeated at the department level, where the OSSOC displaced the emergency operations committee in the Department of Santa Cruz.

<sup>10</sup> <http://www.sphereproject.org/content/view/27/84/lang,English/>

<sup>11</sup> For instance:

- a. At community level: one community health worker per 500-1,000 population; one skilled/traditional birth attendant per 2,000 population; one supervisor per 10 home visitors...
- b. Peripheral health facility (for approximately 10,000 population): total of two-five staff; minimum of one qualified health worker, based on one clinician per 50 consultations per day; non-qualified staff for administering oral rehydration therapy (ORT), dressings, etc. and for registration, administration, etc.

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delivery of an unsustainable level of services to selected groups,<sup>12</sup> creating new inequities and a conflict with the more realistic objectives of the long-term recovery programs. The challenge is to adjust the response to a disaster to the local context. Consistency and sustainability should prevail.

### ***Overlapping between relief, recovery and reconstruction***

Ten years ago, the response to an earthquake triggered immediate life-saving efforts that would taper off after four to five weeks, leaving behind those agencies or NGOs with a development approach to handle recovery. Reconstruction funds would not materialize for several years, leaving the delayed health needs poorly met due to the lack of specific funding for transition from relief to reconstruction (recovery).

The traditional phases of the disaster cycle (prevention, preparedness, response and recovery) were always represented as a continuum. Today however, the post-impact phases overlap more than ever and compete for resources, whether financial or human.

Today, the economic valuation conducted by financial institutions of the damage caused by a disaster is being made just days after the impact, rather than weeks or months later,<sup>13</sup> and consequently, the timeline for receiving pledges for reconstruction has also shortened significantly. At the same time, the generous (and in cases, excessive) funding for humanitarian immediate response in well-publicized disasters encourages first responders to expand the definition of ‘emergency relief activities’ to match the duration of available humanitarian funding. Relief teams may remain active for years. Governments’ efforts to declare an emergency over and initiate the recovery process may be defeated by humanitarian actors.<sup>14</sup> In most cases, the availability of unused relief funds plays a major role in overextending the relief phase.

Mandates are also stretched, resulting in IFRC and WHO leading a process of monitoring “recovery” indicators,<sup>15</sup> which traditional lead agencies for reconstruction (the financial institutions) consider as duplicative of their effort. In addition multiple parallel efforts by

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<sup>12</sup> In this instance, the selected group may be the displaced population rather than the host community, for example.

<sup>13</sup> Conducting early surveys of economic damage (as opposed to emergency needs) presents an additional challenge for the ministry of health, which, during the first few weeks, is deeply involved in the response and has scarce resources to spare for an economic assessment.

<sup>14</sup> In Aceh province, Indonesia, WHO extended its emergency response long after the government had shifted to developmental mode (recovery and reconstruction). In Pakistan, official plans for the return of displaced populations to their place of origin at the end of the winter met with resistance, not from the affected population but from international actors who insisted that displaced families be given the choice of whether or not to continue in camps, with full services including education. Indeed, agencies had extended the doctrine of “voluntary repatriation” beyond conflicts to natural disasters.

<sup>15</sup> Tsunami Recovery Impact Assessment & Monitoring System (TRIAMS)

<http://www.humanitarianinfo.org/sumatra/reliefrecovery/livelihood/docs/doc/inforesources/ConceptPaperonTRIAMSImpactMonitoringSystem.pdf>

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humanitarian agencies, reconstruction institutions and government to redevelop the health system lead to duplication and inconsistencies.

### ***Redefining disasters and emergencies: shifting priorities***

The prevention and management of the effects of climate change, terrorism and other security issues cannot be ignored, and indeed, are medium to long-term priority issues that deserve more action. LAC countries are, however, more vulnerable to natural disasters and technological accidents. However, since September 11, 2001, too much focus has shifted from common technological or natural disasters to terrorism.

There is little rationale to abandon a multi-hazard, multi-phase approach to disaster mitigation, preparedness and response at regional and country level. Global political concerns and the availability of earmarked funds should influence, but not dictate, country action.

### ***The changing role of financial institutions***

The interest and role of regional and global banks (Inter-American Development Bank and the World Bank) have evolved over the last several years.

#### The World Bank (WB):<sup>16</sup>

A new policy aims to facilitate the WB's support to "social aspects of recovery within the relief-to-recovery continuum."...*"In today's emergencies, the Bank is being asked to step in earlier and under a wider variety of situations, often as part of integrated international support for a country's emergency recovery plan. This means that the Bank's first response-the needs assessments and technical assistance-is often carried out while relief activities are under way"*<sup>17</sup>

The Global Facility for Disaster Reduction and Recovery (GFDRR), established in June 2006, is already a major player in the disaster management field through its support of UNISDR. Australia, Canada, Denmark, European Union, Italy, Japan, Spain, Sweden, Switzerland, UK and World Bank are contributing to the GFDRR.

In brief, the WB is asserting its role (and leadership) in the early recovery, an area where the humanitarian community was rapidly expanding, often without the necessary development expertise.

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<sup>16</sup> An "Evaluation of the World Bank Assistance for Natural Disasters" by the Independent Evaluation Group (IEG) of the WB, 2006, led to the document entitled *Toward a New Framework for Rapid Bank Response to Crises and Emergencies* (R2007-00 10), made public in April 2007. Online at [www.worldbank.org](http://www.worldbank.org) (search using the title for a link to the PDF document.)

<sup>17</sup> (R2007-00 10) Changing Role of the World Bank, p.3.

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The Inter-American Development Bank (IDB)

The IDB approved its Disaster Risk Management Policy in 2007.<sup>18</sup> The purpose of this policy is to improve the Bank's ability to assist the borrowing member countries in the attainment of their development goals in sustainable economic growth, poverty reduction and promotion of social equity, by supporting their efforts to proactively manage disaster risk.<sup>19</sup>

The new policy has two interrelated objectives:

- i) “To strengthen the Bank’s effectiveness in supporting its borrowers to systematically manage risks related to natural hazards by identifying these risks, reducing vulnerability and by preventing and mitigating related disasters before they occur; and
- ii) “To facilitate rapid and appropriate assistance by the Bank to its borrowing member countries in response to disasters in an effort to efficiently revitalize their development efforts and avoid rebuilding vulnerability”<sup>20</sup>

The policy adopted by the IDB’s Immediate Response Facility, which links eligibility for emergency funding to a country’s commitment to preparedness, is a positive step.

***The revised International Health Regulations (IHR 2005)***

The IHR, which were initially adopted in 1969, were revised in 2005 to include any “illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans,” including therefore issues resulting from the natural, accidental or deliberate release of chemical or radionuclear material. The management of technological disasters is potentially becoming an international concern.<sup>21</sup>

In 2007, WHO dedicated World Health Day to “Health Security” and upgraded its department of communicable diseases at headquarters to cover emergencies caused by chemicals and other environmental hazards as well as climate change. How IHR 2005 and the redistribution of roles within WHO will reflect on the Ministries of Health in the Region remains unclear.

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<sup>18</sup> Disaster Risk Management Policy, 28 February 2007. Online at <http://www.iadb.org/sds/doc/ENV-DRMPolicy.pdf>

<sup>19</sup> Quoted from [http://www.iadb.org/sds/ENV/site\\_2970\\_e.htm](http://www.iadb.org/sds/ENV/site_2970_e.htm)

<sup>20</sup> IDB Disaster Risk Management Policy p.3

<sup>21</sup> In English: [http://www.who.int/csr/ihr/IHRWHA58\\_3-en.pdf](http://www.who.int/csr/ihr/IHRWHA58_3-en.pdf) or in Spanish: [www.who.int/csr/ihr/WHA58\\_3-sp.pdf](http://www.who.int/csr/ihr/WHA58_3-sp.pdf)

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## ***The Humanitarian Reform***

Few practitioners doubt that the international humanitarian system was in need of serious reform. The lack of clear mandates “*has repeatedly led to ad hoc, unpredictable humanitarian responses, with inevitable capacity and response gaps in some areas.*”

“*Humanitarian reform seeks to improve the effectiveness of humanitarian response by ensuring greater predictability, accountability and partnership.*” In September 2005 the UN Inter-Agency Standing Committee (IASC) agreed to designate global “cluster leads” – specifically for humanitarian emergencies – in nine sectors or areas of activity.

“*The approach is designed around the concept of partnerships between UN agencies, the International Red Cross and Red Crescent Movement, international organisations and NGOs.*<sup>22</sup> *Partners work together towards agreed common humanitarian objectives both at the global level (preparedness, standards, tools, stockpiles and capacity-building) and at the field level (assessment, planning, delivery and monitoring).*”<sup>23</sup>

One concern for LAC is the fact that the voting membership in the IASC, the governing mechanism for the humanitarian reform, is limited to UN agencies, with other key humanitarian actors (ICRC, NGOs etc.) serving as non-voting members. Donor governments have been instrumental in this reform. What has been missing in the design and implementation of the proposed partnership is a voice from the affected countries, which are responsible for directing humanitarian assistance to their population. Due to a lack of awareness, the humanitarian reform process is perceived as a mechanism of the United Nations System and not of national and regional actors.

Leadership for issues in the health sector is also distributed among several Clusters: nutrition, water and sanitation, mental health (as a topic under the Protection Cluster) and finally ‘health’ *per se*. The former two are led by UNICEF and the latter by WHO. It is a major and regrettable departure from the holistic definition of health as it appears in the WHO constitution and a step backward from coordination practices in LAC.

Fortunately, an increasing number of States with an emerging economy and working institutions are reclaiming their responsibility and demanding adjustments to a mechanism that is designed primarily for response in failed or ineffective states.<sup>24</sup>

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<sup>22</sup> It is noteworthy that local governments are not mentioned as part of the partnerships.

<sup>23</sup> Inter Agency Standing Committee (IASC). Guidance note on using the cluster approach to strengthen humanitarian response 24 November 2006

<sup>24</sup> For example, in recent disasters, Mexico, Nicaragua and Peru chose not to accept the activation of the Cluster mechanism.

## **Implications at country and sub-regional levels**

### ***At country level***

Changes in the humanitarian system are not merely operational, but strategic and political as well. They redefine whose disaster it is and establish rules of accountability. These changes may affect all countries of the Americas.

Although most of the changes are intended to benefit the affected population, the implications for countries in LAC may be profound in the case of large scale disasters. The disadvantages may partly offset the expected benefits.

- The Ministries of Health will find it difficult to influence how the large amount of available funding is allocated.
- Few Ministries of Health are familiar with the mandates, roles, strengths and weaknesses of an increasing number of actors (civil or military, private or public).
- The Cluster approach, if not guided by the health authorities, may result in a transfer of leadership from the national level to a donor-driven international system, further marginalizing health coordinators in Latin America and the Caribbean.
- In the absence of national humanitarian assistance standards adapted to the level of development and preexisting services in the affected country, unrealistically high “minimum standards” are applied for the duration that humanitarian funds are available.
- A post-disaster assessment of impact (economic valuation), using the ECLAC methodology, is taking place much earlier, while the health sector is still fully absorbed in the immediate medical and public health response. The earlier the economic valuation takes place, the greater the shortage of qualified health assessors.
- International humanitarian relief agencies are undertaking the reconstruction of health facilities, housing and income-generating activities independently from national development and reconstruction calendars and priorities. The skills and approaches required for emergency relief and response are not necessarily appropriate for development-like recovery.<sup>25</sup>
- International emphasis on immediate (external) response is overshadowing the need for increased efforts in risk reduction and national preparedness. Funds for preparedness and risk reduction are not a standard feature of humanitarian relief grants.
- Ultimately, national institutions may lose credibility and the respect of the population.

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<sup>25</sup> Conversely, development entities are not necessary competent to lead relief and rehabilitations initiatives.

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***At subregional level***

The LAC region has long-standing subregional organizations: CEPREDENAC, created in 1987,<sup>26</sup> CDERA, created in 1991,<sup>27</sup> and CAPRADE, created in 2002.<sup>28</sup> All three are implementing inter-country risk reduction and preparedness initiatives. Because the mandate, resources and ownership of each organization is not the same, their role in emergency response differs greatly.

In preparedness and risk reduction, each agency has developed its own approach and political balance when it comes to securing support from donors and civilian or military actors. Most agencies, including the three subregional agencies, have adopted an opportunistic pragmatism in order to grow and provide services.

There is little precedent in other regions to assess the impact of global changes on sub-regional entities. At the time of major disaster, one can anticipate that:

- Sub-regional organizations are likely to be dramatically understaffed and under-resourced as compared to a fully mobilized global coordination capacity.
- The quality of prior relationships with main actors (donors, UN agencies, NGOs and the military) will determine to what extent the subregional entity will be able to advocate for a meaningful participation of the government in the actual management of international assistance (Cluster leadership, assessment of needs, coordination and timing/planning of recovery).
- A dependency on external funding (in particular bilateral or military sources) may limit the sub regional agencies' ability to take a firm stand before the international community and donors and call for an effective leadership role for the Disaster Management and Civil Protection agencies and the Ministries of Health firmly over external interventions.

## **Conclusions**

The international community's renewed assertiveness in humanitarian response aims to improve a rapid and unimpeded access to external relief assistance by the affected population. It is essentially directed toward the beneficiaries, to whom many humanitarian stakeholders express direct accountability. Indeed, few, if any countries have the capacity to provide large-scale immediate assistance to a population stricken by a major disaster.

The approach, however, is justified often by the lack of sustained investment on the part of the countries in their own preparedness and response capacity. The inability of national

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<sup>26</sup> Centro de Coordinación para la Prevención de los Desastres Naturales en América Central

<sup>27</sup> The Caribbean Disaster Emergency Response Agency

<sup>28</sup> Andean Committee for Disaster Prevention and Assistance

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institutions to effectively manage external resources and be accountable for their response to immediate needs of the affected population is widely perceived and sometimes well-documented.

However, sidetracking national institutions once past the extremely short lifesaving relief in order to mitigate shortcomings is a short-term approach that will not increase capacity in the next disaster, nor will it stimulate countries in LAC to assume responsibilities and international commitments and make a political and financial investment in disaster risk reduction. It is only through the strengthening of national and regional capacity that the potential for humanitarian reform and the changes taking place globally will be fully applied to benefit affected groups in the Americas.

Leadership for response and for recovery is different. For the latter, a long-term development perspective is required. The health sector is seen as lagging behind in recovery/reconstruction.

In brief, national institutions in LAC and other regions have the resources, knowledge and skills to carry out successful programs. They should be persuaded and strengthened to act rather than be substituted by international actors.