

CHAPTER 5.

COORDINATION OF DISASTER RESPONSE

ACTIVITIES AND ASSESSMENT OF HEALTH NEEDS

The response to disasters, both by nations affected and from the international community, has gradually improved in Latin America and the Caribbean in the last 30 years. With the evolution of national disaster management agencies, disaster response by governmental and nongovernmental institutions is better coordinated and based on pretested advance plans.

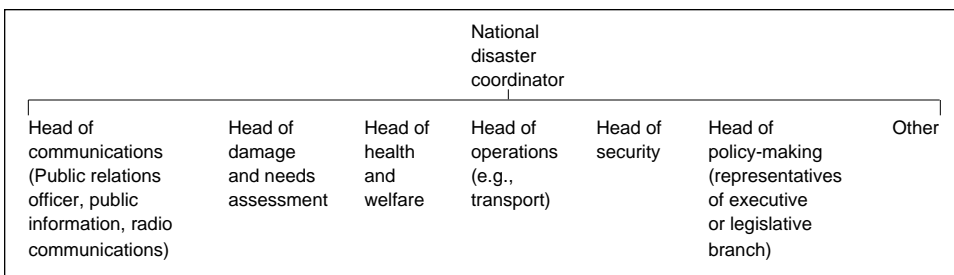
NATIONAL EMERGENCY COMMITTEE

After a disaster, all resources of the affected country are mobilized. Ideally, they are placed under the direction of a single national authority in the National Emergency Committee, in accordance with emergency legislation adopted beforehand. This Committee should be attached to the national disaster management agency and assumes overall disaster response coordination from a designated Emergency Operations Center. The National Emergency Committee is chaired by the President of the country or by his/her representative. Where there is an impact on the health situation of the population, the Health Disaster Coordinator will provide the link between the overall national disaster management authority and the health sector. The Minister of Health or his/her representative is the official health representative on the National Emergency Committee.

Membership of the National Emergency Committee will vary depending on the nature of the disaster. For example, its composition during a complex emergency would differ from that during a cholera epidemic. Figure 5.1 illustrates a proposed organization for the Committee. The organization will reflect each country's specific administrative, social, and political structure. Final responsibility for equipment such as heavy vehicles and telecommunications, the authority to request or accept external assistance, and clearance to issue news releases on health matters will probably lie outside the health sector.

In support of this national structure, the United Nations system in each country has established a Disaster Management Team. That team is chaired by the U.N. Resident Representative and is composed of the heads of U.N. agencies present in the country and in some cases of major bilateral agencies and NGOs. Chapter 13 discusses the role of international agencies in humanitarian assistance.

FIGURE 5.1. Members of the National Emergency Committee.



Note: These members are usually permanently stationed in the Emergency Operations Center during the disaster response phase. Membership is according to the hazard. Other officials should be invited for special briefing sessions.

HEALTH EMERGENCY COMMITTEE

In case of disaster, the major function of the Health Disaster Coordinator is to advise, or execute on behalf of the health sector authority (e.g., Minister of Health) operational coordination and to mobilize all possible health resources to save lives and limit material losses to the health sector.

In support of these activities, a Health Emergency Committee is convened. This Committee will include senior representatives of the health ministry, sanitation and water services, major accredited voluntary agencies, and other ministries involved in health relief programs. In contrast to the standing advisory committee for disaster preparedness mentioned, which has a large membership, the size of the Health Emergency Committee should be limited. Meetings that include too many staff members have impeded quick and efficient decision-making in several disaster situations.

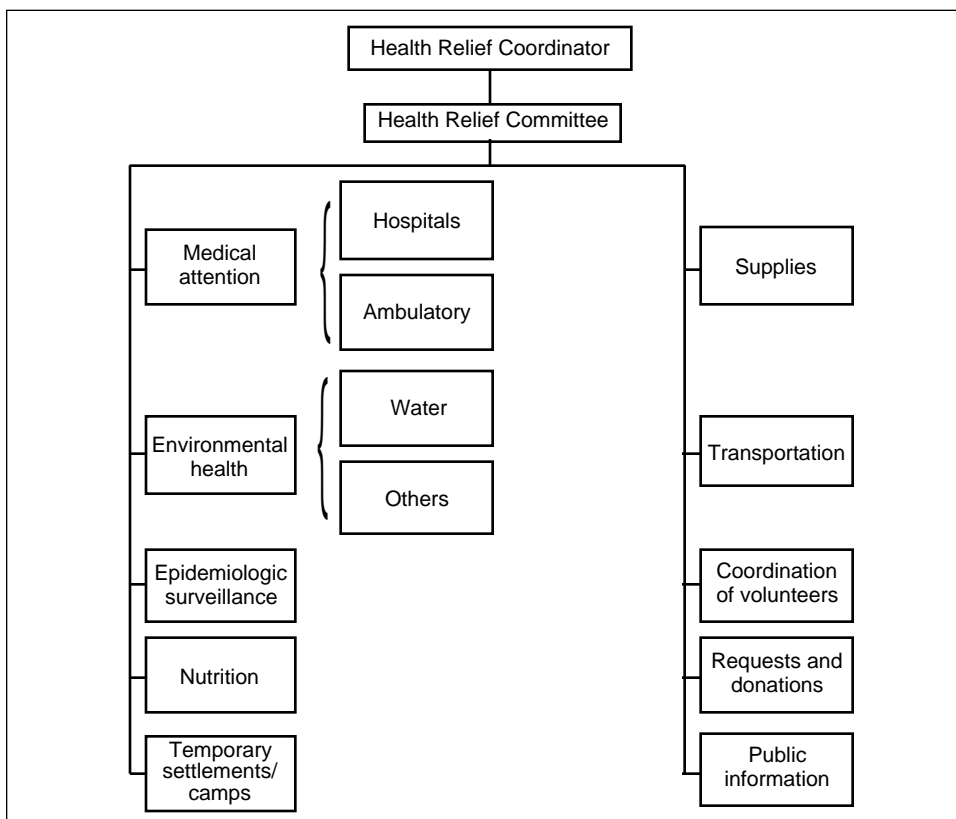
A press or communications officer should be attached to the Health Emergency Committee to disseminate information and decisions (see Chapter 3).

Figure 5.2 illustrates the functional areas that the Health Disaster Coordinator and Health Emergency Committee should consider in organizing humanitarian operations. Several activities, such as transportation, supply management, and volunteer coordination, must be integrated with the corresponding areas of the National Emergency Committee (Figure 5.1). The health transportation unit, for example, will work closely with and under the direction of the National Emergency Committee’s transport section.

Should the creation of the National Health Disaster Management Program have been overlooked, a senior health official must be appointed in the immediate post-disaster phase to represent the health sector on the National Emergency Committee. His or her tasks, with the support of the Health Emergency Committee, will be to direct the sector’s relief activities and set its priorities, clear news releases, approve requests for external cooperation, and accept or reject offers of assistance on behalf of the Minister of Health.

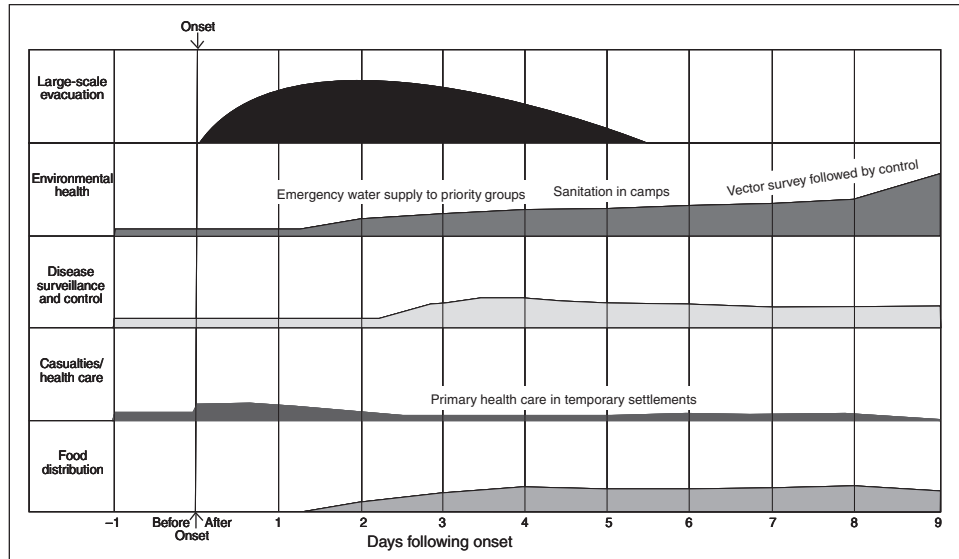
ASSESSMENT OF NEEDS

The major administrative problem in many relief operations is the mass of conflicting and often exaggerated reports about the extent and effects of the disaster.

FIGURE 5.2. Coordination of Health Emergency Activities.

Factual information is necessary to meet three main objectives: to define the affected population; identify and anticipate its unmet needs by assessing the extent of damage and existing local human and material resources; and identify potential secondary risks to health. The Health Disaster Coordinator will also require information in order to keep the international assistance community abreast of the changing situation so that it can respond appropriately; provide verified facts to the national and international media in order to avoid unsubstantiated reports, such as of disease outbreaks, that may provoke inappropriate responses; and keep the local population accurately informed about available services and prevent or counteract rumors.

Timing of the information is usually more important than its completeness and accuracy, as decisions need to be made as soon as possible in the emergency phase, with the data that are available. Within the first few hours of the hazard impact, authorities must have an idea of the overall extent of the disaster, allowing them to take the first decisions for the general population affected. Subsequently, data will be progressively adapted to a smaller scale, culminating, if possible, in the satisfaction of individual needs.

FIGURE 5.4. Changing needs and priorities following floods/sea surges.

and international agencies; key people and organizations active in relief; and the location of potential evacuation areas.

Computerized geographical information systems offer a very promising tool for storing and displaying these data. They require a significant and sustained commitment of human resources to maintain, however, and it is difficult to justify their use exclusively for disaster response. As mentioned earlier, they are most commonly used for a country's development and planning processes. Where GIS exist, they should include the essential information to help authorities make decisions in a post-disaster situation.

METHODS OF GATHERING INFORMATION AFTER HAZARD IMPACT

Information can be obtained in five main ways: from aerial observation (light aircraft, helicopters, satellites); reports directly from the community and relief workers; reports from the media; regular reporting systems; and surveys.

Aerial Observation

Low-altitude overflights may yield rapid information on the geographic extent of damage and major damage to bridges, roads, and other specific lines of communication. This information is of limited use in determining the operational capacity of facilities and damage to underground installations, however. Helicopters have great flexibility and health workers should try to use them early on in needs assessment.

Satellite imagery is rapidly replacing aerial observation. Although satellite images are extremely valuable in determining the extent of physical damage,

they are, at present, of little use in identifying the needs for urgent medical care.

Reports from the Community and Humanitarian Workers

Reports are received from community leaders, administrators, and local authorities, but they often have serious information gaps, since they lack information about isolated, severely affected communities. The respondent may have little accurate information to report, and may exaggerate the importance or urgency of some needs. Where reasonable doubt exists, the health assessment committee should not accept requests for large-scale relief at face value, but should try to discover why a particular need is said to exist. Humanitarian teams sent to affected communities should also be instructed to provide basic information on health needs and the community's ability to cope with them.

Reports from the Media

The international and national media provide rapid reports on damage and health needs. Their technical relevance, accuracy, and completeness usually do not match their speed and coverage. An increasing number of decisions are based on those reports, however, as they are a valuable source of information for health authorities when planning and orienting their professional assessment of the situation.

Regular Reporting from Existing Facilities

Where communications can be reestablished rapidly, information must be sought directly from administrative centers, public and private hospitals, and other technical agencies about immediate medical care, water, food, and sanitation needs. As noted in Chapter 7 on disease surveillance, epidemiological techniques are particularly useful in gathering and evaluating this information.

If large numbers of casualties are expected, for instance, daily reports should begin to be gathered from major health facilities as soon as possible after the impact to determine their ability to cope with the increased load and their need for support. A standard reporting format should be used by all components of each agency (health ministry, social security agency, armed forces, NGOs, and the private sector). The information collected should include the number of casualties appearing for treatment each day, other patients, admissions, vacant beds, and deaths. If possible, attendance and admissions should be reported by broad age and diagnostic categories.

Essential material in short supply such as casting plaster or x-ray film and specific food, water, and power problems also should be reported.

Surveys

Objective and quantified information on certain health needs can be obtained only through systematic surveying. If existing information sources are inadequate or inaccurate, suitable surveys should be conducted as soon as possible. After a major disaster, surveys may be organized in the following three stages:

Stage 1

Within the first 24 to 48 hours, an initial rapid assessment of damage—called “quick and dirty”—generally conducted by helicopter and sometimes based on satellite imagery, delineates the affected area by examining all potentially affected areas. The physical condition of health, transport, and communications facilities, as well as the status of relief activities should be quickly assessed by gathering information provided by one or several of the above mentioned methods. This will be sufficient to establish the types of problems that have arisen, to serve as a basis for mobilizing specific relief, and to design more formal surveys. The initial survey is generally carried out with the assistance of the armed forces and the participation of international experts (e.g., PAHO/WHO and U.N. Disaster Assessment and Coordination Teams).

Familiarity with the area to be surveyed is most important. Participation by health professionals in the survey will be an asset, but is not essential, as the data are not highly technical and can be gathered by others.

There is generally a conflict between the need for assessing the overall problem and the urge to provide immediate humanitarian assistance. To resolve this, surveillance personnel should refrain whenever possible from giving medical care, and backup medical assistance must be provided.

Stage 2

During the second phase of assessment, which may vary from a few hours up to several days after the impact, a detailed multidisciplinary health survey must attempt to include all affected areas.

During the first days, a survey in outlying areas should include an assessment of the numbers of casualties and dead. A survey of health needs must be a part of emergency care so that the survey team can call in immediate medical backup. Information should be collected on: (1) the total number of casualties; (2) number requiring evacuation and their major diagnostic categories; (3) number requiring local treatment; (4) availability of essential health supplies and personnel; (5) continued aftercare likely to be needed for those receiving emergency treatment; and (6) need to supply or make temporary repairs to local medical facilities.

The detailed survey will also try to assess the immediate impact of the disaster on water quality and availability. The aim is to estimate the extent to which damage to water supply systems and other sanitation services immediately increases health hazards (e.g., transmission of diseases) when compared to pre-disaster conditions, not to assess their absolute quality.

The need for food, shelter, and protective clothing must also be assessed.

In contrast to the initial rapid survey, it is essential to have the most qualified available health professionals take part in this survey, since major humanitarian operations will be based on the findings. At least one survey team member should be chosen for his or her familiarity with local conditions. Since technical competence and prior experience in disaster assessment are major assets, regional or international personnel may have to be called on to provide expertise unavailable locally. Neighboring countries should consider pooling such resources before disasters occur, based on principles of technical cooperation among developing countries.

Transporting survey teams must be given highest priority, since other relief activities will be competing for available transportation. Specifically, survey team space should be sought on all relief transport if the teams do not have their own transportation. Helicopters are the most flexible and useful transport for such surveys.

Stage 3

In the third assessment stage, surveys of specific problems must be made. Damage to health facilities and related utilities should be surveyed throughout the affected area by competent technicians and engineers. These surveys will provide a basis for estimating reconstruction costs. If such cost estimates are not quickly available, scarce international relief funds cannot be suitably channeled to priority areas in the health sector. Finally, these surveys will start the continuing surveillance needed to direct health sector assistance activities rationally.

Too often, disaster managers have confused the assessment of emergency humanitarian needs with the evaluation of rehabilitation and reconstruction requirements. Humanitarian agencies and donors expect immediate data on the emergency needs and not on estimates of the long-term economic impact of damages and the cost of subsequent redevelopment. These data should be collected, but at a later stage.