



A secure and disaster-resilient
health sector
in the Americas

Strategic Plan

2008 - 2012

of the Pan American Health Organization



**Pan American
Health
Organization**



Regional Office of the
World Health Organization

FOREWORD

“If you do something for me and you do it without me, then you do it against me.” This quote from Jawaharlal Nehru aptly describes the philosophy behind this strategic plan developed by the Area on Emergency Preparedness and Disaster Relief of the Pan American Health Organization, regional office for the Americas of the World Health Organization.

The aim of the Area on Emergency Preparedness and Disaster Relief is to make an increasing difference in helping countries in the Americas and other Regions to reduce the health sector’s risk to all types of disasters, with the ultimate goal of reducing morbidity and mortality following such emergency events, while at the same time improving the health of the population of the Americas.

It has been more than 30 years since PAHO/WHO’s Member Countries requested the Organization to help strengthen their national response capacity through the efficient use of existing resources. We look back at 1976 as a pivotal year, when the Directing Council made the decision to include the topic of disaster response in the health sector agenda. Over the years, this initiative has expanded to include preparedness, mitigation and other risk reduction activities.

Today, it is common to see disaster preparedness, mitigation, response and risk reduction reflected in PAHO/WHO policy documents and decisions. The Health Agenda for the Americas clearly points to natural and manmade disasters as factors that limit the achievement of health sector goals and the PAHO/WHO strategic plan for 2008-12 reflects an even greater level of commitment on the part of the Organization to disaster risk reduction. The recent decision of the WHO General Assembly to consider disaster preparedness as one of the Organization’s 16 Strategic Objectives and the subsequent decision to elevate Health Action in Crises to the Organization’s highest administrative level—a Cluster—only confirms the visionary approach taken by the countries of the Americas more than three decades ago.

This area of work is also critical to the advancement of the health agenda in the Americas and the achievement of the Millennium Development Goals. There is no doubt that any major event that impacts a country in this Region has the potential to significantly constrain the entire Organization’s goals and objectives. Disaster risk reduction is not the concern of any one single entity within PAHO but rather it is now a corporate priority.

Within the context of this Region, the following strategic plan for a secure and disaster-resilient health sector in the Americas establishes a clear vision and delineates our priorities of reducing disaster risk and mitigating the impact of disasters on the population’s health and well-being, a collective responsibility and commitment of the Pan American Health Organization.



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1. Background

In 1976, the Member States requested the Pan American Health Organization, regional office for the Americas of the World Health Organization (PAHO/WHO), to establish a Program on Emergency Preparedness and Disaster Relief (PED) to help strengthen the countries' response capacity to natural disasters through the efficient use of existing resources. Over the last three decades, the scope of this initiative has expanded to include risk reduction and to improve the resilience of the health sector to disasters.

PAHO/WHO recognizes that disaster prevention, risk reduction, preparedness and recovery form parts of a continuum of activities and that most often these phases overlap. In fact, the only moment that is clearly defined in time is the moment in which a disaster occurs, shifting the continuum from preparedness into response (and subsequently recovery) mode.

Within this framework, and in the current planning cycle, the range of technical cooperation activities has expanded to encompass an 'all-hazards' approach. Examples include the methanol intoxication in Nicaragua (2006), the multisectoral crises due to hemorrhagic dengue and yellow fever in Paraguay (2006/2008), the population displacement in Colombia (ongoing), the incidents of civil strife in Bolivia (2007) and the demands to prepare for phases 5 and 6 of pandemic influenza. The health issues stemming from these emergencies are now becoming an important part of national public agendas as a priority of many governments.

This trend will continue, perhaps at a faster pace, as the public's expectations of the state's ability to respond and even prevent all type of disasters increases. This reality, coupled with expectations on the part of the international community that countries will have institutions capable of handling all aspects of disaster management, even in mega-events on the scale of the Asian tsunami, requires the Organization to re-position itself. New challenges such as climate change are emerging, which will require us to re-assess the risks to public health and levels of vulnerability of populations in the Region over the next five years and beyond.

The countries of Latin America and the Caribbean have made considerable progress in reducing the health impact of major emergencies and disasters. Many ministries of health have a stable disaster preparedness and response unit or office with responsibility for covering all types of disasters (multi-hazard), and in most countries, they can count on strong political support. They have a permanent structure as well as a minimal full-time professional staff and a defined (although insufficient) budget. In the hierarchy of the

ministry, they have access to the highest level of decision making and clearly reach out to other sectors.¹

Although national level disaster preparedness is relatively well-advanced in the Americas, historically our work has tended to progress in isolation from initiatives in other regions of the world. The last five years has shown us that more and more institutional players are becoming active in the health preparedness and risk reduction field and that we can no longer be an 'island', separated from the broader international health community. During the next strategic period, the Organization must take into account this new situation and look more systematically at initiatives taking place in other parts of the world. We will also continue to focus on new and innovative areas to which this Region and the Organization can contribute, as part of global efforts to improve risk reduction in the health sector.

In response to the evolving regional scenario and drawing on lessons gleaned from past experiences, this Strategic Plan addresses two broad aspects of institutional disaster management. The first relates to aspects of disaster risk reduction,² the developmental aspects of our technical cooperation, which involve both day-to-day and long-term activities. The second is related to the humanitarian response side of technical cooperation, which requires lean, fast, and flexible mechanisms for short-term but highly effective measures. We recognize that the Organization must engage in both modes of operation to fulfill its mandate.

This 2008-2012 Strategic Plan for the Area on Emergency Preparedness and Disaster Relief coincides and is in line with PAHO/WHO's organization-wide Strategic Plan 2008-2012 (approved by Member States in October 2007). The PAHO/WHO strategic plan reflects an even greater level of commitment to disaster risk reduction. This enhanced corporate involvement has been due, in part, to WHO's establishment of a high-level strategic objective.³ This commitment must now become a collective responsibility of many technical divisions and country office programs. We must also focus on this Region's unique challenges and opportunities. These enable us to move beyond a common set of objectives and to continue building country capacities in accordance with the commitments and requests of the member states in benefit of the most vulnerable populations.

The objective of this document is to define PAHO/WHO's corporate strategy for delivering effective technical cooperation to enable the health sector in the countries of Latin America and the Caribbean to reduce risk, prepare for and respond to disasters and emergencies, while at the same time creating a body of knowledge and lines of action that benefit the health sector beyond the Americas.

¹ Progress Report on National and Regional Health Disaster Preparedness and Response presented to the Pan American Health Organization, 47th Directing Council., September 2006.

² For PAHO, "disaster risk reduction" refers to actions aimed at reducing the hazard, the vulnerability or both. It encompasses prevention and mitigation. 'Disaster management' covers the full range of interventions: prevention, preparedness, mitigation, response, recovery and reconstruction. Although this is not the ISDR definition, PAHO uses disaster risk reduction in this sense due to the characteristics of its clients.

³ Strategic Objective 5 (SO5): 'To reduce the health consequences of emergencies, disasters, crises and conflicts and minimize their social and economic impact'; Strategic Plan 2008-2012, October 2007.

2. Strategy

2.1 Vision

Natural and other man-made events will always occur and we will never be able to prevent them from happening completely. But there is much that can be done to reduce the risk and to better prepare for disaster events to limit the impact on the population's health, especially the poorest and most vulnerable. It is also our duty to our member states to be as well prepared as possible to respond to any event, be it a localized emergency or a multi-country 'mega-disaster'. Our long-term vision for Latin America and the Caribbean is therefore of a future when there is adequate, nationally-led and sustained capacity to reduce disaster risk in the health sector, both to prevent damage to infrastructure and service delivery and to provide a timely and effective response to disasters.

To achieve this vision, PED will maintain its cooperation in the traditional areas of disaster preparedness, mitigation and response, which form the core pillars of our programming. We will continue to approach everything we do with the constant and underlying aim of supporting our member states and their health sectors. However, developments in the international humanitarian framework and the regional context of operations as well as evolving risks outlined above require new initiatives and ways of working to meet the challenges of this coming five year plan.

2.2 Our strategic objectives

a. Improving disaster preparedness capacity in the health sector

We will strive to support our national partners in developing a well-prepared health sector disaster program with leadership, credibility and coordinating authority within the national context, which encourages the engagement and participation of a wide variety of partners, such as NGOs and the private sector.

To achieve this, we will contribute to building national preparedness through a range of interventions and approaches including: advocacy and technical support for updating and improving sector policy and legislation; continuous training of new partner organization staff as well as personnel of Ministries of Health; the provision of scientific information to inform preparedness; support for improved plans and procedures; and the provision of targeted financial and human resources to improve preparedness and the facilitation of partnerships.

b. Protecting health services from the risk of disasters

We will work toward improving the safety of health services. These measures will focus on ensuring the functional continuity of health service delivery during and following a specific event; it also will seek to better protect health personnel, equipment, infrastructure and non-structural assets from the impact of disasters.

It is essential that health services, buildings and physical facilities are better protected from locally relevant hazards. We include here the full range of health services, from

large complex hospitals in urban centers to small, single-room health posts serving dispersed rural communities. Our focus is always on the continuity of service, including in instances of outbreaks of disease or epidemics, rather than solely on infrastructure. We will provide expert technical support and develop new tools for assessing risk and to better train the health workforce. We will also work with our major development partners in the Region to encourage greater investment in mitigation. We will actively lobby at global level for the promotion of the World Disaster Reduction Campaign “Hospitals Safe from Disasters.”

c. Supporting countries to respond to disaster events in the health sector

Our mission is to strengthen national capacity to respond to all types of emergencies and disasters that have public health consequences—whether natural, manmade (including acts of terrorism and/or conflict) or technological in nature. PAHO is a development agency, not a humanitarian agency that distributes supplies. However, in emergency situations we must be ready to respond quickly and comprehensively and be able to operate using procedures similar to humanitarian agencies.

We will continue to support our member states by ensuring their effectiveness and readiness as first line responders to any emergency situation. We will also seek to improve our own readiness to respond by investing in systems and capacities to take direct action in situations where national capacity is overwhelmed. We will ensure that PAHO/WHO is capable to lead the health cluster for the Western Hemisphere when called upon.

d. Forging stronger relationships with our national, regional and global partners

Over the last decade, humanitarian response to disasters has become a growth industry, with many new actors entering the field or old ones renewing and strengthening their involvement. The time when PAHO was the only international health actor in the Region in the aftermath of disasters is past. Member countries now have a greater number of partners in the health sector, and international organizations are developing new approaches and initiatives all the time. We must develop and deepen our partnerships, both within the Region and globally, to learn more effectively and contribute to the Region’s own valuable experiences and lessons.

Today more than ever, PAHO must clearly demonstrate its value added and must reach out to be part of the global network of multisectoral actors in disaster risk management. We will achieve this by increasing our collaboration with partners within and outside the health sector, and by establishing new communication mechanisms and networks with governments, donors, civil society groups and other UN Agencies. We will move away from direct delivery of services and towards a more brokering or facilitating role in support of our member states.

e. Mainstreaming health disaster risk reduction across all our institutional partners

There is now a growing recognition that disaster risk reduction is a development concern, and should not be seen only in the context of a humanitarian response to an

emergency. To have truly sustained impact at scale, we must advocate for the integration of elements of risk reduction that address health concerns across the day-to-day activities of both our own organization and those of our partners.

We will approach the objective of mainstreaming by improving our internal and external communication strategies and by promoting common language and clear concepts about disaster risk reduction as primarily a development concern. We will strive to elevate the disaster risk reduction agenda to the highest levels of the Public Health Forum by developing technical and operational capacities across PAHO/WHO in support of countries in crises. We will use our technical expertise and leverage to influence the thinking of our major partners, both Ministries of Health and others at national and regional levels, to better address risk reduction and to ensure that risk reduction principles and activities form part of and support other health initiatives such as primary health care, patient safety, workers' health and other efforts that contribute to the Millennium Development Goals.⁴

f. Changing attitudes and behaviors surrounding emergencies and disasters

Misperceptions and inaccurate information abound with regard to the public health impact and management of emergency and disaster situations and have been major factors leading to inefficient and ineffective post-disaster actions that have diverted time as well as human and financial resources away from areas for which they were most needed.

In the past, PAHO/WHO has worked to educate health decision makers and the public about what is and what is not appropriate international health relief assistance, what is involved in the management of dead bodies, or how disasters can affect communicable disease patterns. We will continue to work with organizations and agencies as well as the media to replace common disaster myths with authoritative health information. By helping to change how people react to and behave in disasters and by improving the public's overall understanding of the health impact of these events, we hope to contribute to building disaster-resilient communities.

2.3 How will we work?

Each member country has different needs and varying capacities and levels of resources available to its respective health sector. As a consequence, we recognize that there is no one blueprint way of working that can be applied to all country contexts. We also must work with our regional and international partners, which will require yet other ways of working. In order to meet these demands and to achieve our strategic objectives, we will select from a range of functional approaches, which can be grouped into the following categories:

a. technical support: much of our core business is aimed at training and capacity building of national level partners, with a focus on government Ministries of Health. We will continue to support our public sector partners, but increasingly reach out

⁴ Indeed, it would be difficult if not impossible for any major health initiative to reach its goal if dramatically affected by a disaster.

through programs of technical support and advisory services to new partners, including civil society networks and the private sector;

b. advocacy: we are mindful that we cannot achieve our objectives on our own, especially when these rely on changing underlying policy, legislation and investment decision-making processes. Therefore, we will proactively lobby key development partners such as the International Financing Institutions and Ministries of Planning and Finance, and others to promote disaster management at all levels;

c. information and knowledge management: based on many years of experience, we know that information is a powerful, relatively inexpensive and indispensable tool for decision making by all actors. We will continue to conduct, learn from and share the results of post-disaster lessons learned exercises and produce authoritative information on health issues, both in developmental and emergency situations. We will continue to set regional standards through guidelines and publications and to develop new and innovative mechanisms for dissemination, making appropriate use of evolving technologies;

d. facilitation and coordination: we recognize the increasing importance of partnerships in the health sector and the need for strong coordination, particularly in the fast-moving humanitarian response context. We will use our extensive networks and access to key decision-making fora in the Region to contribute to coordination efforts. Our leading role in the U.N. health Cluster will be instrumental in this effort;

e. direct action: in situations where there is the need for direct intervention (situations that exceed the local capacity to respond), the PED program will continue to be involved in providing services on the ground, both through our regular staff based in headquarters and sub-regional offices as well as through our specialist response teams. Although we may intervene directly in such cases, we will always work in support of our member states and relevant health authorities. Our focus will be on the crisis management aspects of all hazards, while the Organization's other subject matter experts will aid with the technical aspects.

2.4 Who will our partners be?

PAHO has a core mandate to support and provide services to member states in the health sector. As such the PED program has historically focused on key government partners, most notably the ministries of health in the Region. This will continue to be the case, but in addition we will seek to expand partnerships and collaboration over the coming five years to include a broader range of actors in the health sector as well as those outside the sector, who nonetheless are critical for achieving our strategic objectives.

Health sector partners

- **PAHO country offices:** through our network of disaster focal points, but also working across all relevant technical departments, such as communicable diseases, health services, mental health and environmental health;

- **Ministries of Health:** supporting the Disaster Management Programs or Units within ministries, but also providing training and technical support to other departments dealing with preparedness and rapid response at both central and decentralized levels, including the national focal points for International Health Regulations (IHR) and other subject matter experts;
- **NGOs and civil society networks:** we will make increasing efforts to engage with and provide support to civil society organizations that are active in the health sector, both at national and regional levels;
- **Other health providers sharing common strategic objectives:** social security, security forces and private providers operate in all countries, either formally or informally; in a number of countries they are legislated to provide services. We must work harder to reach them and advocate for them to make greater efforts to address disaster risk as in many countries they are the most important health care providers;
- **International organizations:** we will continue to collaborate with agencies that are important players in the health sector, such as the International Federation of the Red Cross and Red Crescent Societies, UNICEF, and others.

Other partners

- **Ministries of finance and planning:** we will continue to engage key ministries as part of our efforts to integrate risk management into the everyday business of government, especially to improve investment in mitigation measures;
- **Police, civil defense and military forces:** we recognize the critical role that these forces play, particularly in rapid response, and will continue to provide training and technical support;
- **Media and journalist networks:** the way in which disaster events are portrayed to the public is increasingly important and the media has a key role in presenting a balanced view of the importance of risk reduction. We will make new efforts to engage with the media and provide technical information and orientation;
- **Universities and other research centers:** we already collaborate with a range of academic institutions, particularly in the area of information management; these efforts will continue with an increasing shift in the development and dissemination of technical information from regional to country level. We will seek out new partners, such as meteorological offices, to be better informed about the likely impact of climate change;
- **International financial institutions:** we will build on our existing relationships with the main IFIs, including the World Bank and the Regional Development Banks and look to establish more structured and systematic relationships to improve our advocacy work. Our close working relations with ISDR will facilitate this process;
- **National and regional disaster management coordination bodies:** PAHO was instrumental in the creation of CDERA, CEPREDENAC and CAPRADE and we will continue to play a prominent role in these important sub-regional disaster reduction mechanisms. We will continue in our privileged role as coordinator of the disaster preparedness and response working group of the Organization of American States;
- **International humanitarian agencies:** we are part of a broader network of humanitarian agencies and will continue to work with UN agencies, international

NGOs and the Red Cross National Societies and the IFRC, both during emergency response and on a regular basis. When called upon, we will act as the health sector Cluster lead within the framework of the IASC coordination system.

2.5 Where will we work?

PAHO is responsible for providing services in support of the health sector to *all* member countries in the Region. As such, the PED program will continue to work in all sub-regions. However, we recognize that individual countries have differing capacities and needs and that they may require different types of technical support for a number of reasons, including underlying health indicators, development of the health sector and level of vulnerability to hazards. There may also be priorities based on underlying structural or political problems. Specific populations may also be at higher risk, for example, indigenous groups that make up significant minorities in certain countries.

Therefore, we will continue to provide a base level of support and engagement in all member countries, including maintaining a response capacity in all parts of the Region. We will focus additional attention and resources on a number of priority countries identified on the basis of their high exposure to hazards, high vulnerability to disasters, high levels of poverty and lower levels of preparedness. These are countries that the Organization has also identified as priority countries based on current health indicators: Bolivia, Guyana, Haiti, Honduras and Nicaragua.

PAHO will also work closely with countries that have been particularly successful in disaster management in the health sector, in order to enhance their capacity to share experiences and experts before, during and after disasters.

2.6 Who are our intended beneficiaries?

The disaster management programs of national health authorities (ministries of health) and other health sector institutions will continue to be our main target in the coming strategic plan period. We will target our assistance both at central or national level and at sub-national levels where appropriate. The extent to which we target our assistance to sub-national entities will be determined on a case-by-case basis, depending on capacity and progress toward decentralization in each country.

Given the connections between health and social and economic factors such as income, education, housing, labor, and social status, we will place emphasis on the most vulnerable populations in both urban and rural areas. Special consideration will be given to the identification of and support to socially excluded groups, such as marginalized indigenous populations, displaced people and low income families, among others, in areas that are more likely to be affected by disasters. We will identify these vulnerable and marginalized groups in consultation with central government authorities, ministries of health and other partners who may represent the special interests of these populations, such as NGOs and civil society organizations, stressing the importance of respect for intercultural beliefs and the

incorporation of human rights-based perspectives into all activities and program implementation

Given that disasters impact women and men differently, special attention will be given to gender issues during the implementation of this strategic plan. Gender equality mandates have emanated from global and inter-American conferences, where governments committed to promoting gender equality in the formulation of all public policies and programs. Responding to these mandates and in line with this long standing commitment, PAHO's Directing Council adopted a Gender Equality Policy in September 2005 that applies to all facets of its work. The policy calls for including gender-sensitive focus and analysis in all aspects of technical cooperation, development of national policy frameworks and management of human resources.

PED will develop a stronger commitment to collect and analyze humanitarian data disaggregated by age and gender. This will be achieved through development of forms that include this variable and including this requirement in all training of disaster experts on needs assessments (Regional Health Disaster Response Team, national counterparts, etc.). We will also promote gender in health issues with our partners and in the development of our technical information.

3. Situation and Vulnerability Analysis

3.1 The Latin America and Caribbean context

Latin America and Caribbean countries are extremely vulnerable to a wide variety of natural hazards

Each year, an average of 130 natural disasters of varying degrees of magnitude occurs in the Region. In the period 2001-2005, the impact of these destructive phenomena left a death toll of some 20,000, and 28 million victims.⁵ Although it is becoming increasingly more difficult to pinpoint with precision how exposed the population is to these threats, it is widely estimated that 73% of the population and 67% of health clinics and hospitals in 19 countries⁶ in the Region are located in high risk areas.⁷

Natural and man-made disasters also have a devastating impact on countries' economies. In 2005 alone, hurricanes were responsible for more than US\$ 205 billion in losses, with 7 million people affected in the Region of the Americas⁸. Damage to the small countries and economies of Central America and the Caribbean was estimated at more than US\$ 2.22 billion, revealing their vulnerability and the need for

⁵ Health in the Americas 2007, Regional Volume. Coping with Disasters. Pan American Health Organization.

⁶ The countries included are: Anguilla, Argentina, the Bahamas, Belize, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, French Guiana, Guadeloupe, Guatemala, Guyana, Haiti, Honduras, Martinique, Nicaragua, and the Turks and Caicos Islands.

⁷ Source: Survey on the Health Sector State of Preparedness and Mitigation to Disasters, prepared by the Area on Emergency Preparedness and Disaster Relief – March to July 2006.

⁸ Preliminary Overview of the Economies of Latin America and the Caribbean. Economic Commission for Latin America and the Caribbean (ECLAC): Santiago de Chile, 2005.

prevention and mitigation plans and measures. In Grenada alone, economic losses from Hurricane Ivan (2004) represented 253% of the country's GDP.⁹

The vulnerability of urban populations is growing fast and rural people remain at risk

Disparate socio-economic development drives people to migrate from rural to urban areas or to emigrate in search of jobs and a better life. Overall, the urban population in Latin America and the Caribbean grew from 65 to 78% between 1980 and 2005; the rate of growth was less in Central America and the Spanish-speaking Caribbean and Haiti. The uncontrolled growth of urban areas in the Region is a matter of urgent concern. In most cases, urbanization is not accompanied by a well designed development plan and in some cases with a complete lack thereof. In the 1950s, only two cities had more than 10 million people. Today, more than 20 cities meet this criterion and most are in poor countries. As urbanization continues, much of it poorly planned, the vulnerability of urban populations is of increasing concern. Higher population density and more complex physical infrastructure have the potential for a greater disaster impact, while at the same time, urban populations often have a poor understanding of their vulnerability. Rural areas also suffer from ongoing problems of poverty, limited resources, and a lack of access to health services and environmental degradation.

Latin America and the Caribbean is often considered as a middle-income region, but much of its population still lives in extreme poverty

After years of stagnation, economic growth in Latin America and the Caribbean has resumed. Notwithstanding, there is an enormous gap in income distribution in the Region (measured by the Gini coefficient)¹⁰ and this gap has not closed to any degree between 1990 (Gini of 0.383) and 2002 (Gini of 0.403). These inequalities result in poverty and their intensity is exacerbated in vulnerable segments of the population such as households headed by women, certain ethnic groups, rural populations or migrant communities. An estimated 41% of the population in Latin America and the Caribbean is poor and 17% is indigent.¹¹ Economic disparity has caused pockets of extreme poverty that, in certain circumstances, may breed violence in the aftermath of natural disasters (looting, theft, domestic violence, etc.).

Despite past progress, the Region suffers from a lack of trained human resources

Despite all the effort put into disaster management training over the past years in the health sector, there continues to be a lack of human resources. Where staff has been trained, it is often difficult to track individuals due to high levels of turnover in the civil service, particularly following political change in governments. Wholesale turnover following elections and other management changes can be a very significant constraint to building sustained human resource capacity within ministries. Hence, new health personnel and other key actors need to be continuously trained to ensure they are in place and available when needed for the development of activities involving mitigation, preparedness and response.

⁹ Economic Damages: Share of GDP, by Natural Disaster and Country (2005), International Strategy for Disaster Reduction. www.unisdr.org/disaster-statistics/top50.htm.

¹⁰ The Gini coefficient measures the inequality of income distribution or inequality of wealth distribution.

¹¹ Data from the Strategic Plan of the Pan American Health Organization 2008-2012.

In some Caribbean countries with small populations and limited government capacity, it is common for one person to have to perform a range of different duties with multiple responsibilities. In such cases, where there is insufficient staffing and budget, it is unreasonable to expect the designation of a full-time disaster manager in the health services.

Vulnerability to disasters constrains development efforts and reinforces poverty

Vulnerability to disasters is a significant constraining factor to the achievement of the Millennium Development Goals (MDG) in the Region. Exposure to disasters increases the vulnerability of the poor, deepening their poverty and preventing them from taking advantage of economic opportunities, thereby reinforcing their poverty in a downward spiral. As well as impacting individuals and households through the destruction or loss of assets, disasters can have a devastating impact on macro-economic performance and can set back development gains by decades. For example, the devastation caused by Hurricane Mitch in Central America in 1998 resulted in US\$ 58 million of damage in Honduras alone; this equated to the loss or disruption of access to drinking water for 75% of the population, or approximately 4.5 million people.¹² But even developed countries are not immune. Hurricane Katrina was the most destructive natural disaster in U.S. history. The overall destruction wrought by Hurricane Katrina, which was both a large and powerful hurricane as well as a catastrophic flood, vastly exceeded that of any other previous US major disaster. Estimates vary but, considering property damage alone, Hurricane Katrina is America's most costly disaster—natural or man-made—with a price tag that approached the \$100 billion mark.¹³

PAHO's disaster risk management activities are designed to contribute to human well-being, minimizing the negative effect of disasters and maintaining achievements in public health by responding to the health needs of vulnerable populations affected by such events.

Conflict and insecurity are a significant issue in some parts of the region

Social and economic inequalities and poverty are known factors that contribute to internal conflicts and civil strife and have a direct impact on the health of the population. Despite the relatively stable situation of the Region, a number of internal conflicts that caused significant internal population displacement have created new challenges for the health sector. These events may increase over the next five years.

As well as the conventional notion of insecurity and the threat of violent conflict, we are seeing a new development in terms of the collective fear of pandemic outbreaks of communicable diseases, which are now perceived as 'national emergencies' and as significant threats to security in a broader sense.

¹² Global Water Supply and Sanitation Assessment 2000 Report; WHO

¹³ "The Federal Response to Hurricane Katrina: Lessons Learned." Online at www.whitehouse.gov/reports/katrina-lessons-learned.pdf

There is an increasingly crowded field of actors working in health emergencies in the Region

In past decades, PAHO was one of the very few, if only truly international organization working in health emergencies and humanitarian response. This situation has changed dramatically, with Hurricane Mitch perhaps marking the threshold into a new era, characterized by a proliferation of actors in disaster preparedness and response. These include an expanded UN system, international NGOs, the Red Cross and Red Crescent movement and increasingly active bilateral donors. The effective coordination of so many agencies is becoming a major challenge, especially at the interface between the international community and national government authorities; competition for funding is progressively increasing. We must adapt to this changing operational environment and provide effective leadership and coordination in our core technical discipline.

3.2 Changing profile of hazards and risk

Although natural hazards remain the most common threat to countries in the Region, we will face new and more challenging hazards emerging in the coming years. In the last few years, for the first time governments declared national emergencies for previously unrecognized reasons such as the ethanol intoxication in Nicaragua, ethylene glycol in Panama, SARS in Canada or dengue in Paraguay. These emergency situations had the potential to overwhelm national health services and presented challenges in areas such as clinical management, information and communications.

The emerging threat of **pandemic influenza** in 1997 and later in 2003 revealed that epidemics do not constitute a sufficiently important part of national disaster plans. Despite recent planning, the health sector is still inadequately prepared to face this type of threat. Another very significant change is the public's perception of these situations. Diseases such as dengue, which were until recently considered only as a medical issue, are increasingly viewed through the same lens as bioterrorism or pandemic flu: they cause fear and are increasingly seen as a threat to security, the economy, tourism or other non-health areas. Therefore, perhaps the strongest contribution a disaster management expert can make is to assist society, during phase 5 and 6 of a potential pandemic, to use all available resources to reduce, to the extent possible, the impact on health. This coincides with our definition of coordination.

Exposure to **toxic chemicals** is a serious public health problem in the Region. The volume and variety of these substances has increased, and WHO estimates that per capita exposure to some, such as pesticides, is two times higher than the global average. Although improving, the reporting of morbidity and mortality from acute and chronic poisoning does not reflect the magnitude of the problem.

Technological hazards pose significant potential risks for countries that have reached a certain level of industrial development. Little has been done in terms of regulation and prevention, and the health sector is poorly prepared to face a large-scale chemical, radiological or other technological disaster. This risk will most probably increase in tandem with economic development and the globalization of trade.

3.3 Climate change

Climate change has implications for disaster risk management, as it impacts the exposure to hydro-meteorological hazards such as storms, floods and drought and also modulates underlying risk factors, which influence the vulnerability to environmental hazards and therefore the probability of disaster occurring.¹⁴ The effects of climate change—direct or indirect—also have an impact on disease vector distribution and subsequent changes in the distribution of infectious diseases. Planning for improved disaster risk reduction must recognize that climate change alters the magnitude and frequency of extreme events and that we can no longer rely solely on historical patterns of hazard and risk profiles. Response mechanisms and economic planning for disasters therefore must take these new variables into account.

Disaster response planning must engage in a much more proactive way with the meteorological sector to factor in local and global environmental issues that change risk patterns and increase vulnerability. In Guyana, for instance, the government has begun discussing the relocation of the capital further inland to cope with anticipated rising sea levels due to global warming. The capital, Georgetown, is below sea level and regularly floods after heavy rains or storms.

3.4 International humanitarian reform

The UN Inter-Agency Standing Committee (IASC) is the primary mechanism for inter-agency coordination of humanitarian assistance. The IASC, composed of UN and other humanitarian agencies, has changed the way in which humanitarian assistance is coordinated and delivered. Assistance is now organized around nine clusters, each of which is responsible for all activities related to its topic, regardless of whether the government, an NGO or a UN agency is implementing them.

PAHO/WHO is the recognized leader for the health Cluster in the Americas. Within PAHO, the PED program is the liaison office for OCHA and all other humanitarian actors and remains the focal point for the humanitarian reform initiatives.

The responsibilities of the health Cluster leader in cases involving a large international response are complex and far-reaching and require certain skills that not all PAHO staff have. In these situations, the Director will assign a senior disaster specialist whose functions will be to exclusively ensure independent coordination. While giving a key role to government/local authorities, PAHO will focus specifically on the Cluster responsibility in health coordination, but will ensure that the Organization's public health subject matter experts actively collaborate in other Clusters, such as nutrition and water and sanitation, without which health interventions would fail or be seriously compromised.

3.5 Changing profile of member states

Several countries such as Argentina, Brazil, Chile, Cuba, Mexico and Venezuela, are increasingly developing their external cooperation strategies, offering human and

¹⁴ Sperling F., Szekely F. Disaster Risk Management in a Changing Climate, May 2005.

other resources during emergencies. These countries are essentially becoming new contributors in the Region and are taking on some aspects of more traditional donors. However, this is an evolving process and these countries are still in the early stages of learning how to function as a provider of assistance; it is likely to be some time in the future (five years or more), before these countries move to direct large-scale funding possibilities.

PAHO has many years of experience in interacting with international donors and as the interface between international assistance and national government recipients; we will therefore support the process of the changing role of these emerging regional donor countries through engagement with both national health authorities and Ministries of Foreign Affairs.

4. PED Program Strategic Lines of Action

4.1 Improving disaster preparedness capacity in the health sector

'A health sector disaster program with the leadership, credibility and coordinating authority within the national context, which also integrates the participation of a wide range of partners, including NGOs and private sector operators.'

Although emergency preparedness is an important pillar of PAHO's technical cooperation and a prerequisite for effective emergency response, the issue continues to be 'politely' overlooked by the international community and on national political agendas. PAHO is in a unique position to continue to promote the need for a strong national disaster program in Ministries of Health, including staff and a funded work plan that serves as the nation's centerpiece for all health issues related to disasters. In order to protect what has already been achieved and to maintain a strong institutional "disaster" memory (which can be easily lost due to high staff turnover), the strengthening of the health disaster programs will remain our strategic priority. We will accomplish this by continuously lobbying to maintain these offices, provide adequate budget and staff, allow access to the Ministry's highest decision making level and providing access to the most up-to-date training opportunities and information.

Over the next five years we also will reach out beyond our core constituency of the Ministries of Health and make a concerted effort to engage with and support other health players, such as NGOs and private sector operators. We will make technical information and some training available to them and provide coordination and facilitation services to improve communication and learning both across these groups and with government health authorities. We will adopt the following lines of action:

- **Strengthen health disaster programs in Ministries of Health:** increase the focus on multi-hazards and previously un-addressed risks such as chemical accidents and pandemic influenza; develop scientific linkages to better understand the potential impacts of climate change on both disaster risk and health; promote the

adoption of benchmarks to demonstrate institutional commitment to DRR; assist member countries to better monitor and evaluate progress; support drills and simulations and improve response to mass casualty events;

- **Improve partnerships for disaster preparedness:** enhance the Ministries of Health leadership roles at national level by improving coordination within the health sector and with other sectors (i.e., reviewing and testing plans); contribute to improving international humanitarian assistance focusing on health;
- **Support continued training efforts:** develop the management and technical skills of health professionals by ensuring access to specialized training; develop a web based tool, freely accessible and containing an inventory of available training opportunities in health disaster management; incident management systems, etc.;
- **Provide authoritative technical information and publications:** develop new and innovative methodological designs and guidelines; prepare and disseminate training tools and information products that are specifically adapted to country/target audience needs; improve access to sources of technical information through both conventional and digital means.

4.2 Protecting health services from the risk of disasters

‘Better protected health services – including staff, management systems, equipment, assets and physical infrastructure - that are safe and remain functional during and after a disaster event’

The devastating effects of natural hazards are not due exclusively to nature. They are also due to failures in the development process, resulting from the lack of consideration of the impact of existing natural hazards. In other words, a disaster could potentially be avoided if all necessary measures were taken to ensure that whatever is planned, designed, built or maintained is done in such a way so as to ensure that it can continue to function following high-intensity events.

Evidence has shown that the cost of building a new disaster-safe hospital or health facility is negligible when measures are included in early design considerations. For the vast majority of new health facilities, incorporating comprehensive disaster protection from earthquake and weather events into designs from the beginning will only add up to 4% to the cost.¹⁵

Public health professionals have the scientific and institutional responsibility to ensure that all health development projects are “hazard-proof.” Although the health sector has successfully instilled the concept that “prevention is better than cure,” much remains to be done to ensure that this applies to disaster risk reduction.

The concept of reducing vulnerability is appealing, but to achieve this requires that all levels of the Organization look at new ways of delivering technical cooperation that are safe from disasters. Because the scope of this task is vast and the resources

¹⁵ Protecting New Health Facilities from Disasters: Guidelines for the Promotion of Disaster Mitigation, Washington D.C., PAHO/WHO 2003.

of the Organization and the member countries are limited, it is recommended that PAHO concentrate its efforts on the initiative “**Hospitals Safe from Disasters**”; the target identified by its 2004 Directing Council and endorsed by 168 countries at the 2005 World Conference on Disaster Reduction (Kobe, Hyogo, Japan, 2005). The hospitals safe from disasters initiative focuses on a specific, easy to identify target that is simple to measure, visible and multisectoral in nature.

To transform the theoretical concept of health sector risk reduction into practice, health disaster coordinators, ministers of health and other health professionals have agreed to concentrate on making all new hospitals and other health care systems disaster-resilient, as an indicator of progress in risk reduction.

WHO and International Strategy for Disaster Reduction, with the support of the World Bank and technical assistance from PAHO, have jointly launched a two-year (2008-2009) World Disaster Reduction Campaign whose theme is “Hospitals Safe from Disasters.” We will have a full-time staff member working on this initiative and will continue collaborating with the ISDR in this endeavor. To achieve this goal we will adopt the following actions:

- **provide technical support to member countries:** to identify and develop Hospitals Safe from Disasters as a national policy; technical cooperation for the development of a national disaster mitigation program; develop and promote new tools (such as the hospital safety index, an inventory of safe hospitals, and multimedia training tools) that help countries to identify risk; assist countries to adapt and apply national benchmarks for risk reduction in the health sector in order to measure, monitor, and report on progress toward reaching the goals of the Hyogo Framework for Action;
- **support the development of human resources and networks:** expand the Region’s human resources base for disaster risk reduction; strengthen and render operational a regional network of technical experts in disaster mitigation, the DiMAG – Disaster Mitigation Advisory Group - and other new networks for chemical and radio-nuclear emergencies, making their services available to any region of the world; support and develop training initiatives in disaster mitigation, such as a course that leads to certification in disaster mitigation;
- **facilitate partnerships and coordinate:** strengthening partnerships with scientific and technical institutions and professional associations to facilitate access to the latest scientific knowledge by health professionals; spearhead a regional initiative to make hospitals safe from disasters; establish an inter-regional mechanism (at global level) for mutual exchange of successful experiences in disaster risk reduction in the health sector;
- **advocate for safer health services:** promote integration of health disaster mitigation measures into the regular procedures of financial institutions, mainly in investment loans and grants (World Bank, Inter-American Development Bank, Economic Commission for Latin America and the Caribbean, Caribbean Development Bank, Andean Finance Corporation, etc.); lobby for recognition of the issue of disaster risk reduction in the health sector; actively promote activities within the scope of the World Disaster Reduction Campaign “Hospitals Safe from Disasters” at country level.

4.3 Supporting countries to respond to disaster events in the health sector

'A health sector disaster program with the capacity to respond quickly and effectively to events, with the guarantee of timely and appropriate regional support in cases when national capacity is overwhelmed'

PAHO's primary mandate in disaster situations focuses on national and international coordination, the quick and independent assessment of health needs and the immediate provision of specialized public health advice. In certain cases, the Organization implements public health projects that no other agency or institution is in a position to do, providing support to other areas in PAHO/WHO whose subject matter experts are better positioned to take the lead. The Organization will also forge alliances with and provide support to various national partners. PAHO/WHO as Cluster lead for the health sector in the Western Hemisphere will ensure that a coordinated response is provided and that the Ministries of Health retain a leading role. PAHO/WHO will coordinate with other UN agencies and it will support countries to make use of the Central Emergency Response Fund (CERF) when necessary.

We will focus on strengthening the Emergency Operations Center (EOC) that has been established at PAHO Headquarters, whose main responsibility is to channel emergency information. The EOC captures and analyzes information and provides it to the Executive Management. It also serves as a physical space to promote communication among all parties active in the response and to facilitate rapid decision making. The speed with which information is received is critical to the task of an EOC. In the event of a major disaster, PAHO will make full use of support available from WHO Geneva, but will give priority to a response team consisting of nationals from the Region.

During the next five years we will promote the Logistics Support System (LSS) for adoption by other humanitarian organizations such as OCHA, with the expectation that other agencies will take the lead in the implementation of LSS in post-disaster situations. The future of LSS will have to be decided at the end of the next five-year period.

For the most part, countries are now self-sufficient in responding to small disasters. Future efforts will focus on dealing with medium-size emergencies, with support from neighboring countries, recognizing that outside support is, and always will be, needed if a major disaster strikes. Sometimes international assistance overshadows national authorities, even when they are able to manage the response. We will always strive to assist and to strengthen our member states' response capacity. PAHO will assist member states to ensure quick recovery of the population following major disasters. We will work with the World Bank to mainstream preparedness and mitigation measures into health sector reconstruction activities. We will adopt the following lines of action:

- **facilitation and coordination for improved response capacity:** support Member Countries in mobilizing human and financial resources to address the health impact of disasters; assist countries to coordinate the health response through the establishment of mechanisms such as Emergency Operations Centers; coordinate

with communicable disease experts in the implementation of the IHR; facilitate decision making at national and international level by providing timely and accurate information on the health impact and priorities; activate and lead the health Cluster as part of the international response when the Cluster approach is implemented by the UN; contribute to WHO global efforts in disaster response by promoting the exchange of experts between the Pan American Health Response Team and other regions; ensure that the health sector impact is reflected in post-disaster socioeconomic assessments conducted by ECLAC and other institutions;

- **training and building of national capacity to respond:** practical and updated tools, guidelines, and technical advice for an authoritative diagnosis of the health situation in the aftermath of disasters; promote the systematic documentation and analysis of the health impact of disasters, including lessons learned exercises;
- **direct intervention to support a national response:** mobilize logistical teams for management of humanitarian supplies and health equipment and a pool of experts in health logistics as part of the Pan American Regional Health Emergency Response Team; promote transparency and efficient management of humanitarian assistance LSS/SUMA and its use by other agencies and countries; deploy the Pan American Health Emergency Response Team in case of disasters and increase the participation of national experts through agreements (MOU) with specialized agencies or institutions; support the organization and set up national response teams; identify members for specialized subsets of the Regional Health Emergency Response Team (mental health, epidemiology, etc); coordinate and execute emergency and recovery projects following the immediate response, by developing a team of qualified project managers.

4.4 Forging stronger partnerships with our national, regional and global partners

‘A well-informed and coordinated network of health sector and other partners at national and international level that share a common vision of nationally-led and sustained capacity to reduce disaster risk.’

For many decades, PAHO has worked in the Americas as one of the few international health sector actors. This situation has changed dramatically in recent years and we now must do more to reach out and work with our international development partners and humanitarian agencies. We will be more proactive in our collaboration with external partners – ranging from regional disaster management bodies, to donors and UN agencies – but we will always be mindful of our underlying mandate, which is to support the national capacity of our Member State health sectors.

There must be better and more open communication among all actors to ensure that we do not duplicate efforts, leave gaps in our assistance, or place inappropriate demands on our national partners, who already function with limited resources. One of the first tasks for us will be to clearly communicate our goals and this strategy to our partners. We will rely on existing coordination and collaboration mechanisms, such as the REDLAC (Risk, emergencies and disasters in the LAC region), which comprises key humanitarian players such as OCHA, UNICEF, ISDR, IFRC and international NGOs. We will also work in support of the ISDR work plan. To improve our relationships with partners we will adopt the following lines of action:

- **support and facilitate coordination networks:** investigate the development of a thematic platform with partners on health and disasters; actively participate in national, sub-regional and regional fora in the health and disaster management sectors; provide targeted financial support to enable facilitation and coordination efforts;
- **act as a broker between our national partners and international actors:** PAHO will act as broker between other actors and the government; support the mainstreaming of health issues into broader disaster management structures; develop joint plans and incorporate health entities (i.e. health disaster coordinators in the Americas) into the strategic plans of regional and sub-regional disaster institutions (such as CEPREDENAC, CAPRADE and CDERA); incorporate disaster issues into sub-regional health bodies (such as REMSAA, RESSCAP, and CCH); research, develop and negotiate formal agreements with other institutions (universities, NGOs, etc.);
- **provide technical information and resources:** continue to support the Regional Disaster Information Center (CRID) that was developed with the support of PAHO, ISDR, MSF, the IFRC and the Government of Costa Rica; provide new technical information and funding of short-term technical staffing requirements or training in support of networks in the Region.

4.5 Mainstreaming disaster risk reduction across all our institutional partners

‘A national health sector that takes disaster risk into account in all aspects of their planning, design, investment and operational activities, supported by international partners that also recognize the importance of reducing disaster risk in the health sector through developmental and humanitarian assistance.’

Hazards such as drought, hurricanes and earthquakes occur naturally and may or may not result in a disaster. The potential for a natural hazard to cause a disaster is a function of the magnitude of the event itself, the vulnerability of a population and its coping capacity. Disaster risk reduction is fundamentally about tackling the underlying elements of risk from natural and technological hazards. Its aim is to reduce the vulnerability of individuals, communities and societies, and to build their resilience or capacity to prepare for and withstand the impacts of disasters. Disaster risk reduction seeks to integrate disaster preparedness and hazard mitigation measures into longer-term development. The goal of disaster risk reduction is to ‘disaster-proof’ development processes.

We understand disaster preparedness, risk reduction and response as crosscutting issues that require proper marketing and mainstreaming if they are to be incorporated into all levels and activities. Mainstreaming requires changing how people react to and behave in disasters and improving the public’s overall understanding of the health impact of these events in order build disaster-resilient communities. Mainstreaming also requires repackaging how disasters are conceptualized and presented in order to ensure a comprehensive policy and practical action plans. External communication includes working together with donors and other actors to present common messages to our national health sector partners and to the public.

We will address the mainstreaming of risk reduction within the health sector both internally by promoting integration across the work of PAHO's other technical divisions and with our national and international partners. We will work in the following lines of action:

- **provide technical support to better address risk reduction:** develop technical and operational capacities across PAHO/WHO in support of countries in crisis, particularly for conducting health assessments, mobilizing resources, coordinating health action, providing guidance and monitoring the performance of humanitarian action in relation to the health and nutrition of affected populations;
- **make available technical information regarding risk reduction:** provide targeted information products to different partners to inform decisions regarding development of policy and operational guidelines to better address risk reduction (health disaster management policies, investment and lending criteria, risk assessment criteria);
- **training and orientation of key decision-makers:** continue and expand the PAHO Corporate Capacity Building initiative; orientation of key IFIs and donor staff active in the health sector in the Region regarding preparedness and disaster management priorities.

5. Structure and Program Management

5.1 PAHO corporate commitment to disaster risk reduction

PAHO was the first WHO Region to formally establish a Disaster Preparedness Unit; (Resolution CD24.R10 following the earthquake in Guatemala in 1976). From that time on, the Organization's commitment to disaster risk management has increased and expanded through a network of sub-regional offices, Country Office Focal Points and disaster focal points in every PAHO area, unit and center.

The strategic plan of the Pan American Health Organization for 2002-2007 named disaster preparedness, mitigation and response as one of its eight priority areas. The Organization's Strategic Plan for the period 2008 -2012 includes Strategic Objective 5 (SO5): "*to reduce the health consequences of emergencies, disasters, crisis and conflicts, and minimize their social and economic impact.*"

The high priority PAHO/WHO places on disaster risk management within the Organization is not only reflected by the weight given to disaster activities within the strategic plans, but also by the different resolutions adopted by member states in support of such activities. These include: 'Disaster-Resilient Health Facilities' (2007), 'Disaster Preparedness and Response' (2004), and a wide variety of Directives issued on the subject. In addition, PAHO helped countries to prepare the Health Agenda for the Americas 2008–2017, launched in Panama in June 2007 by all ministries of health of the Americas. The Health Agenda recognizes disasters as a limiting factor in achieving health sector goals as well as an impediment to the normal functioning

of health services. The Pan American Health Organization's 47th Directing Council endorsed this Health Agenda.

Corporate Capacity Building initiative

Whether in normal times or emergency situations, the decision-making process no longer adheres to a strict hierarchy. The process relies on an increasingly complex and fluid network. In emergencies, all PAHO/WHO staff may, at some point, be linked to critical decisions that impact public health, and this requires everyone to have a common understanding of the Organization's key risk management priorities. In the best interest of both disaster victims and PAHO's national and regional agenda, it also requires consultation, sharing of information, commitment among all hierarchical levels of the Organization and a consideration of differing perspectives and points of view. Risk reduction is a cross-cutting area of technical cooperation, similar to others in PAHO/WHO. Each technical area within the Organization has its specific responsibilities. PED's role is to provide technical guidance with and for countries and to PAHO's other technical divisions and units.

PAHO initiated a corporate capacity building initiative in 2007 to harness the Organization's wide ranging public health expertise and to mainstream disaster management across the Organization. More than 90 high level staff received training on risk management, emergency preparedness and increased their knowledge of the UN Humanitarian Reform.

Although administrative procedures regarding disasters are in place, it is still necessary to clarify or define roles and responsibilities of the PAHO/WHO Representatives (PWR) and senior and executive management in the disaster response phase, particularly in relation to the new Cluster approach. We must also further examine particular issues to ensure a more harmonized approach and to maintain our comparative advantage, fill gaps and address hurdles for internal collaboration.

Based on positive experiences to date, we will continue with the corporate capacity building initiative in the next strategic planning period as an integral part of our in-house mainstreaming efforts and to communicate the importance of disaster risk management across the Organization.

5.2 PED Program staffing and structure

In order to implement this strategic plan and to contribute to PAHO's internal mandate, we will work to ensure that each PWR and Area of Work has at least one expected result that contributes to making the health sector safer from disasters.

The PED program will continue working from its Regional Office in Washington and its three sub-regional offices (South America – Quito, Ecuador; Central America – Panama City, Panama and Caribbean – Barbados); we will maintain our two special initiatives: the Internally Displaced Persons project in Colombia and the Emergency Preparedness project in Haiti. A functional organizational chart is included as Annex 1.

The magnitude and the number of disaster management issues facing the countries are increasing constantly. This has resulted in more projects, more short-term, earmarked funding, and more partners and activities, all of which must be handled with the existing PED staff and structure. In order to face these growing responsibilities, PED has reorganized responsibilities in line with the new PAHO strategic planning and organization. We will:

- create three **Project Coordinators**, responsible for identifying expected results, indicators and milestones for each project, for monitoring progress of plans and outputs and for supporting advisors;
- assign new responsibilities and reporting lines for all **Sub-regional Advisors** who will report to the three Project Coordinators, liaise with PAHO country offices and manage the sub-regional office staff;
- have a regional **Information and Publications Advisor** responsible for the overall strategic direction of all technical information, publications, multimedia, and communications;
- assign direct responsibility to the **PED Area Manager** for oversight of the Sub-regional Advisors and the Project Coordinators.

To better respond to disasters, PAHO created a Disaster Task Force in HQ and a Regional Health Emergency Response Team that reports to the Director. The team leader of Regional Response Team is the counterpart of similar positions in other international organizations or clusters. The command and control mode of operation is different from the business-as-usual approach of the Organization and requires flexibility, good will and seniority on the part of the response team leader, the PWR and the Administration. The change of mode is especially important, as disasters are highly emotional and politically-charged situations. In a matter of days or even minutes, key priorities must be determined.

When necessary, the PAHO/WHO country office will ensure that arrangements are made to establish new sub-offices in an affected area for the duration of the emergency. The size of the sub-office will vary accordingly to the event, but a field response coordinator requires logistic and administrative support as well as technical experts to carry out response activities.

In addition to our own direct staff and the Disaster Focal Points within PAHO country offices, the success of the PED Program depends heavily on the Health Disaster Coordinators within national Ministries of Health. We will continue to support these key staff and to provide them with the highest level of technical training and access to the information and tools that they need to build sustained capacity in their ministries.

5.3 Partnerships for health preparedness

The Area on Emergency Preparedness and Disaster Relief will continue to promote liaison and dialogue with donors and agencies that support health emergency preparedness in Latin America and the Caribbean. PAHO will continue to host periodic meetings, extending invitations to agencies that express interest in making a

commitment to health preparedness or mitigation in the Region. Both internal (e.g. core corporate capacity building process, etc.) and external consultation mechanisms (e.g. sub-regional plans, country cooperation strategy processes, etc.) will also continue to take place.

The direction of PED's future actions will be guided by its relationship with the cooperation activities of other agencies and the expectation of a broader network of experts.

PED will expand its alliances with a growing number of important regional actors in health (both in quality and quantity). In the next strategic planning period, we will create a broader consultation mechanism to serve as a Technical Advisory Group, to advise or comment on general trends and the direction that technical cooperation should follow. In addition, we will work to influence other health and disaster reduction entities to work toward common regional objectives and benchmarks for assessing progress.

6. Monitoring and Evaluation

We recognize that monitoring and evaluation of progress and impact in this technical area form a critical part of our work and we will seek to improve these functions. To achieve this we will seek to approach monitoring through two separate mechanisms or streams.

6.1 Internal PAHO monitoring and reporting

We will monitor progress through our internal reporting systems, which are part of the regular corporate program management procedures, based on the Bi-annual Work Plans, or BWPs. Staff will monitor and collect data and information regarding progress against planned activities in the work plans and assess progress on the basis of indicators and milestones set out in the BWPs. This information will be utilized by the Organization to inform the Region-wide Expected Results, as established in the new WHO Strategic Objective 5.

6.2 PED Program monitoring

In addition to internal monitoring, we will use a more in-depth set of monitoring instruments that is specific to the PED Program itself and which seek to assess the impact of our work. Through this monitoring process, we will seek to address much more qualitative aspects of the program that can help us better understand the true impact of our work. More importantly, we must try to understand the quality of these plans and what impact they have had on improving the continuity of health service delivery during a disaster event.

We took a big step forward in this direction in 2006 when a region-wide survey was carried out by PAHO on the status of health preparedness in the Americas.¹⁶ Although there were limitations to the survey, we consider that the resulting report represents the first attempt toward an objective description of the reality across the Region, focusing on more qualitative aspects of the state of health service delivery and disaster management. This first survey was a major breakthrough in terms of achieving consensus among countries of the need to measure the overall level of disaster preparedness and risk reduction. The baseline data from this survey was used to develop this current strategic plan and in the future we will look to improve the methodology itself and to transform this as the reference tool for regional planning and benchmarking. Ideally, the health data will be used to improve the planning and knowledge of all regional partners.

In addition to the survey, this current Strategic Plan 2008-2012 contains expected results with measurable indicators (i.e. SMART-specific, measurable, achievable, realistic and time bound). This will be PED's main planning instrument and activities will be undertaken as described in this document. A Logical Framework will outline expected results and indicators for the main program components. Each year, PED will prepare a comprehensive annual report that will measure the level of progress toward the achievement of the expected results based on the selected indicators.

We will continue to submit disaster-specific reports as requested and additional informal information throughout the course of the implementation period. We will also report to the Governing Bodies through PAHO's monitoring system. The experience gained during implementation of this Plan may require adjustments to the expected results. External changes in the environment may also require changes in the expected results or activities.

6.3 External evaluations

Building on the monitoring activities outlined above, we will continue to encourage the use of external evaluations. We value the independence and objective rigor that these evaluations have provided in the past. For example, this Strategic Plan has been revised taking into consideration the recommendations from the last Evaluation carried out in 2007 and financed by DFID/CHASE.

We would welcome an external evaluation before the end of the implementation of this 2008-2012 Strategic Plan. As the 2007 evaluation was comprehensive, we propose that shorter evaluations be undertaken at some point mid-way through the planning period to allow for an assessment and adjustment of the plan, based on changes to the operating environment and developments in the health sector and in disaster management in the Region.

¹⁶ Survey on the Health Sector State of Preparedness and Mitigation to Disasters, prepared by the Area on Emergency Preparedness and Disaster Relief – March to July 2006 (<http://www.paho.org/english/dd/ped/CD47-34-e%5B1%5D.pdf>).

7. Assumptions and Risks

We anticipate the successful execution of this strategic plan based on a number of assumptions, most notably that disaster preparedness and risk management will continue to receive strong political support at all levels across member states. We believe that there is now good momentum in this area, driven in part by the successful rollout of the Hyogo Framework for Action, but also because there is increasing political demand from populations in the Region to be better protected by their own governments. Perhaps ironically, any large-scale or so-called ‘mega-disaster’ that may occur in the next five year period would only serve to reinforce demand for better risk management measures. Another key assumption is that all Member States remain relatively stable during the coming five year period, so that we can continue to build on past gains in capacity and knowledge, both at the institutional and individual level.

Within PAHO itself, we assume that the new orientation under the Organization’s Strategic Plan 2008 – 2012 will be executed effectively and that Strategic Objective 5 will be fully integrated into all future PAHO country program designs. In more practical terms, we assume that there will be continued availability of adequate core funding for the functioning of the PED program.

Risks

We can identify a number of risks which may threaten the progress of activities under this PED strategic plan and the achievement of its objectives. We can, however, take a number of steps to make them less likely (prevention) and to address such events if they do occur (mitigation); these strategies are outlined in table 1 below.

Table 1. Principal risks facing the PED Program and likely prevention/mitigation measures

Risk	Likelihood	Severity	Prevention and/or mitigation
Humanitarian response is very demanding in terms of expert time and administrative support. The procedures with which UN organizations must comply are not particularly suited for field operational response activities.	4	4	Changing long-established bureaucratic procedures is a slow and complex process. Instead we will seek to establish clear contingency plans for our own response operations and to secure flexible and fast channels for the immediate disbursement of funds in response to an emergency
The risk of distracting staff from risk management activities to attend disaster response priorities is real. The occurrence of large multi-country disasters, such as the strong hurricane seasons of 2004 and 2005, may seriously affect the implementation of the Program’s work plan.	3	4	We can go some way to addressing this risk by delegating implementation as much as possible to PWRs and technical programs and by refraining from submitting proposals that may be difficult to implement.
Work in the area of emergency preparedness and response can be incorrectly perceived as an additional responsibility that is secondary to the Organization’s regular normative and developmental work.	2	3	With the new PAHO Strategic Plan 2008 – 2012 and the SO5 there is an increased corporate commitment to this area of work, making risk management mandatory. We will build on this institutional commitment by providing relevant information and tools for our colleagues in order to adapt their existing portfolios, without an additional burden of workload.

A secure and disaster-resilient health sector in the Americas
Strategic Plan 2008 – 2012 of the Pan American Health Organization

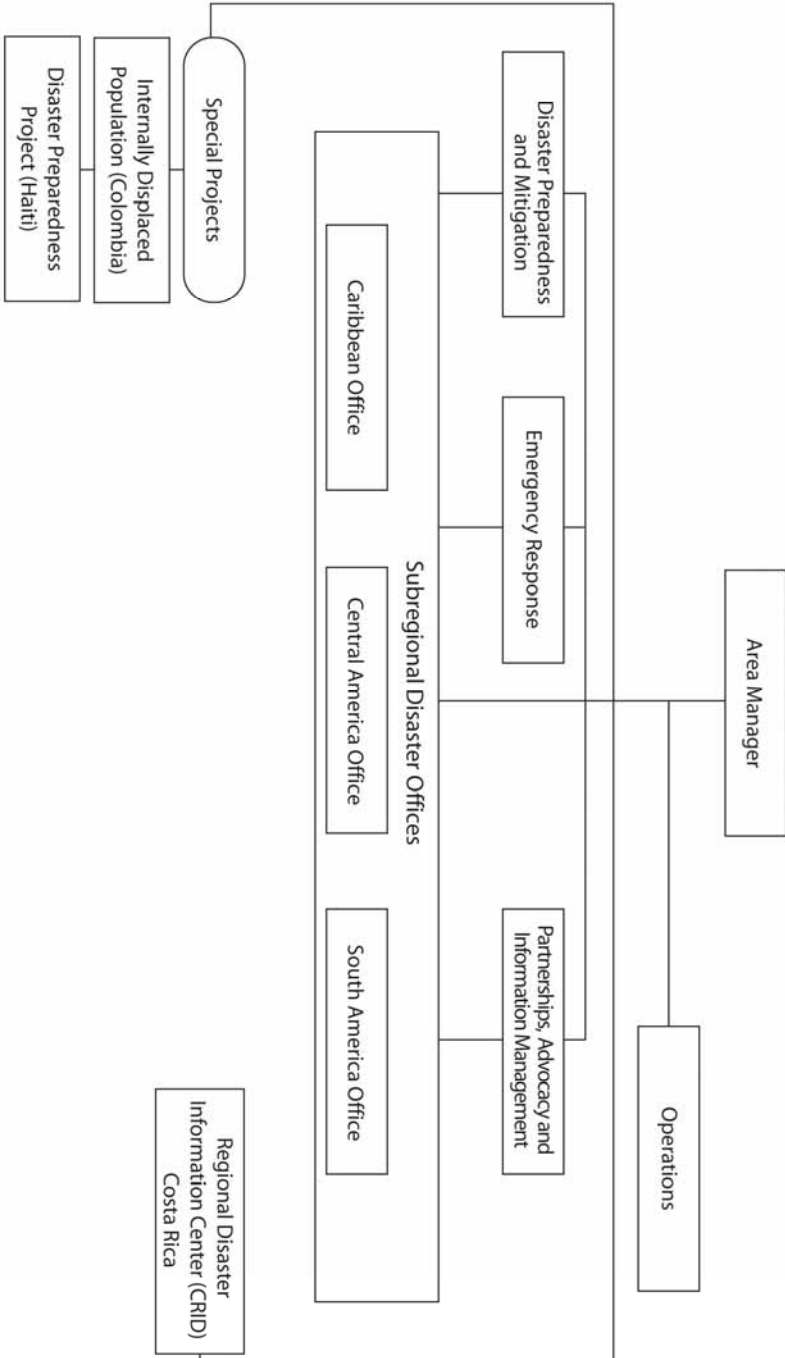
Political changes can result in extreme staff turnover, which can set back our capacity building efforts by years.	3	5	We will seek to institutionalize the program within the Ministry of Health and convince political decision-makers that DRR is an essential core function of the health services.
Lack of qualified staff will hold-back our efforts to build capacity in the health sector.	3	3	We will address this risk through continued efforts at providing training directly and by supporting the planning, design and execution of professional training materials and courses that can be delivered through our established partners.
Lack of involvement of the private sector means that large segments of health service provision may not be addressing preparedness and disaster management adequately.	3	3	We will seek to draw in and engage with private sector health service providers through better targeted communication campaigns and coordination with commercial and professional bodies.

*On a scale of 1 to 5, 1 being very unlikely and 5 being likely

**On a scale of 1 to 5, 1 being trivial and 5 being severe



**Area on Emergency Preparedness and Disaster Relief
 FUNCTIONAL CHART**



Annex 1: PAHO/PED Organizational Chart

Annex 2 Acronyms

BWP	Bi-annual Work Plan
CAPRADE	The Andean Committee for Disaster Prevention and Assistance
CCH	Caribbean Cooperation in Health
CDERA	Caribbean Disaster Emergency Response Agency
CEPREDENAC	Coordination Center for Preventing Disasters in Central American (Spanish acronym)
CERF	United Nations Central Emergency Response Fund
CIDA	Canadian International Development Assistance
CRID	Regional Disaster Information Centre
DFID/CHASE	UK Department for International Development / Conflict, Humanitarian and Security Department
DiMAG	Disaster Mitigation Advisory Group
DRR	Disaster Risk Reduction
ECLAC	Economic Commission for Latin America and the Caribbean
EOC	Emergency Operations Center
GDP	Gross Domestic Product
IASC	Inter-Agency Standing Committee
IFIs	International Financial Institutions
IFRC	International Federation of the Red Cross/Red Crescent
IHR	International Health Regulations (2005)
ISDR	
LSS/SUMA	Logistics Support System / Humanitarian Supply Management System
MDG	Millennium Development Goals
MOU	Memorandum of Understanding
MSF	Medecins Sans Frontieres (Doctors without Borders)
NGOs	Nongovernmental Organizations
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PAHO	Pan American Health Organization
PED	Program on Emergency Preparedness and Disaster Relief
PHP	Partnership for Health Preparedness
PWR	PAHO/WHO Representative
REDLAC	Risk, Emergencies and Disasters in the LAC region

REMSAA	Meeting of the Ministers of Health in the Andean Region , (Spanish acronym)
RESSCAP	Meeting of the Health Sectors in Central America and Panama (Acronym in Spanish)
SARS	Severe Acute Respiratory Syndrome
SMART	Expected Results: S pecific, M easurable, A chievable, R ealistic and T ime bound
UNICEF	United Nations Children’s Fund
USAID/OFDA	U.S. Agency for International Development / Office of U.S. Foreign Disaster Assistance
WHO	World Health Organization



**Pan American
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