

## How Can We Do Better?

While much of the information for improving our response in disaster situations is known, the same mistakes are often repeated. “Lessons learned” may be more accurately titled “lessons identified.” They are not always learned.

This session focuses on what we can do better.... what we can do to remember the lessons experienced and be better prepared for the next emergency.

### **Measuring Results in Health Interventions in Disasters**

Over the years many lessons have been gathered on the monitoring and evaluation of health interventions in disasters. The Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) database, for example, has more than 500 evaluative reports containing lessons. The key lessons point out the need for improving coordination, standardizing methods and indicators, ensuring sufficient and appropriate baseline data, providing appropriate technical expertise and ensuring more commitment to funds to act on recommendations. For future disasters there is a continued and urgent need to bridge the gap between disaster response and development, both in terms of actors and funding mechanisms.

In any emergency -- natural disaster, complex emergency, communicable disease epidemic -- on-going monitoring and intermittent and focused evaluations are needed to measure the physical, psychological and socioeconomic effects of a disaster and the effect of interventions.

Evaluations are especially important in the case of the tsunami, given the large amount of resources invested. Where will these funds go and how will they be used? What are they accomplishing? Evaluations need to clearly examine and compare the results of health interventions undertaken by the local populations themselves, as well as humanitarian and development NGOs, both national and international. Intermittent system-wide, multi-staged evaluations, spaced over the next ten years, are needed to evaluate the tsunami health response.

A proper monitoring and evaluation system requires political and financial commitment by governments, donors and key organizations, not just to implement the systems and to undertake evaluations, but to ACT on them. A clearly identified, recognized and respected coordinating body that has authority to coordinate interventions and evaluations needs to be identified before the disaster occurs – preferably in the disaster preparedness plan. If this does not occur, then from day 1, such a coordinating body needs to be established. Serious discussion must occur regarding the establishment of a regulating body to enforce accepted disaster response principles and standards. Such a body,

which focuses on “disaster malpractice,” requires extensive collaboration among the players.

Baseline data should be collected in the disaster preparedness phase. We need to ensure disaster preparedness plans have standardized assessment forms to ensure key data, disaggregated by appropriate categories, and are collected in a similar manner. For the current tsunami, all assessments that have so far been undertaken need to be gathered and examined to allow for the establishment of a proper monitoring and evaluation system. Due to some of the poor quality of assessments, better assessments must be undertaken immediately to direct interventions and allow for proper monitoring and evaluation.

In summary, measuring results in health interventions in disasters can be improved through these recommendations:

**Recommendation 1:** One agreed upon disaster preparedness plan.

**Recommendation 2:** One designated Disaster Coordinating Authority

**Recommendation 3:** One agreed upon Monitoring and Evaluation System.

**Recommendation 4:** Implement system-wide and multi-staged evaluations (short, medium and long term evaluations over the next ten years) for all major disasters

Serious discussion needs to be undertaken regarding the accreditation of those who respond to disaster and the establishment of a peer regulating body for disaster organizations. Without such a regulating body, the usefulness of monitoring and evaluation systems and reports will continue to be limited.

### **Developing Systems and Capacities for Health Interventions in Disasters**

In developing improved systems and capacities for health interventions in disasters, there are three essential elements: planning, preparedness and practice.

#### **Planning**

Emergency preparedness begins with an emergency plan. National and international bodies should establish time frames for the establishment of these emergency preparedness plans, followed with the assessment of these plans. There should be no health facility system without an emergency preparedness plan, Emergency planning for the health sector should not take place in a vacuum. Other sectors should be involved, and the plans built jointly, rather than attempts made at filling them together later on.

Many guidelines for preparing for and responding to emergencies are already available. Rather than create new ones, existing guidelines should be adapted using participatory approaches by health entities at all levels, preferably a “top down – bottom up” process, using check lists. The World Health Organization can play an important role in providing leadership in creating or adapting such guidelines.

### **Prepare**

In emergency preparedness, it is important to assess what one already has done and assess what resources are available, identifying strengths, risks, vulnerabilities and capacities. Based on this information, well-defined capacity building should take place, using experienced trainers. Capacity building should be continuous and monitored.

Public health infrastructures may need to be strengthened to prevent and mitigate disasters. Emergency teams should be trained, prepared and on-call, ready to respond in high-risk areas. They should be regularly monitored and kept abreast of new developments.

Within the limits of available resources, medicines, supplies, food, equipment and other materials should be stockpiled.

There should be familiarization with and agreement to standards and measures of accountability – the professionalism of emergency preparedness and response. It is too late to develop these once the emergency has taken place.

Coordination mechanisms, frameworks for and divisions of responsibilities, clarification of leadership and followership roles within the health and nutrition sectors and other sectors need to be established well in advance of emergencies, recognizing that they may differ from those used during normal periods of operation.

### **Practice**

Lessons are not learned until they are put into practice. Within local contexts and capacities, emergency drills should be carried out. There should be widespread use and dissemination of guidelines and checklists.

Routine self-assessment to measure vulnerability and the potential for response is recommended, adjusting measures based on new knowledge and experience.

Rather than reinventing the wheel; available resources should be used more efficiently and more effectively, whenever possible.

A cycle of planning, preparedness and practice needs to be created, and this cycle will build continuously, feeding new knowledge and experiences into planning and improving preparedness.

### **Developing Partnerships and Resourcing for Health Intervention in Disasters**

In order to benefit from past lessons, there needs to be movement from talk and commitment to action. Knowing is not enough; we must apply. Willing is not enough; we must do.

Partnerships need complementarities of strength to do more and do it better. Partnerships need commonalities of priorities, mutual obligation to identify partners' strengths and limitations and no duplication of action. Innovation and change is brought into partnerships by people for people.

In a partnership behavior is crucial for people, especially those who are bringing humanitarian aid to other people. Function and dysfunction are linked to behavior, and it is dysfunctional behavior which keeps us from learning the lessons. Dysfunctional partnerships (non-coordination, duplication and waste, eg.) focus on undue competitiveness, struggle for funds, visibility, power and proving themselves rather than helping those in need

A strong partnership is one which is "win-win" for everyone. Individual partners are developed and nurtured within the partnership.

Behavior, however, is not sufficient. We also need good leaders and good managers. Leaders do the right thing. Managers do the things right.

An authoritarian directive is needed if anything of value needs to be accomplished. A leader has the capacity to create a compelling vision, translate it into action and sustain and inspire, keeping the focus, putting down fences and building bridges within each partner.

How can we do better?

First, establish good partnerships in preparedness, working together with others on such activities as

--training drills,

--funding for building capacity within partners, preparedness exercise, maintenance of partners' core competence, mitigation programs in high risk areas for natural disasters;

--transfer of knowledge within and between partners to avoid the organizational syndrome of the "eternal student" and paralysis by analysis; and

--Integrate funding within the broader picture of development.

Second, establish non-conventional partnerships, including the military and private sector. Establish partnerships with the media for strategic communications and as a tool for intelligence gathering and dissemination.

The World Health Organization is a leader in technical advice, global health policy, setting up standards/guidelines/recommendations; research; analysis; liaisons with government and academia. The WHO is a partner to guide and support field operations in an emergency.

In summary, developing partnerships and resourcing for health interventions in disasters can be improved through these recommendations:

**Recommendation #1:** Move from talks to action.....we must change.

**Recommendation #2a:** Develop and adhere to a healthy, highly functional organizational behaviour.

**Recommendation #2b:** Write up partnership agreements (MOUs) as implementing tools, with an accountability clause – not as a document for shelving.

**Recommendation #3a:** Identify leaders around you and give them a platform.

**Recommendation #3b:** Identify the operators/implementers, delegate and empower, trust and let them do what they know best how to do right – without interfering.