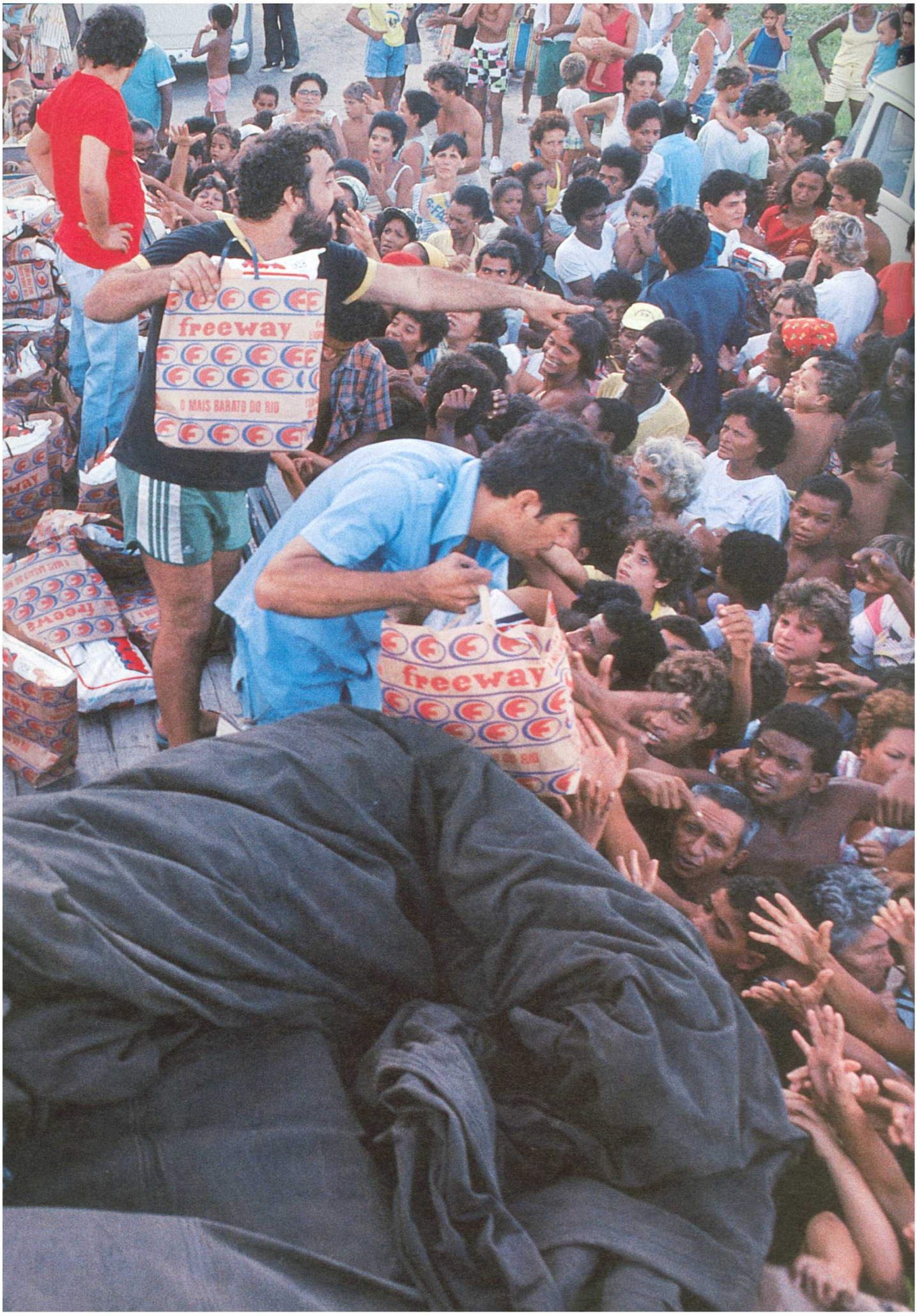
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DISASTER PREPAREDNESS TAKES CENTER STAGE

Societies, much the same as human beings, learn through mistakes and experiences. The countries of Latin America and the Caribbean, after the natural disasters they experienced during the 1970s, were convinced that the key to coordinated response lay in evolving from improvisation to systematized disaster preparedness. This need, which became evident after such catastrophes as the earthquakes in Peru (1970), Nicaragua (1972), and Guatemala (1976), and Hurricanes David and Frederick (1979), gave impetus to an enormous number of preparedness activities in the countries of the Region during the 1980s.

Photo: Gaggero, PAHO/WHO

Photo facing page:

Providing relief to a disaster-stricken community can, at times, lead to chaos and cause a "second" disaster. Following flooding and landslides in Brazil in 1988, food aid is distributed.

THE CENTRALIZED PHASE: STRENGTHENING RELIEF AGENCIES

In the earlier days of disaster response, this field was considered the domain of professionals and experts dedicated exclusively to this task. Specialized relief agencies organized simulations, trained their own personnel, and set up warehouses for the storage of relief material such as tents, blankets, and medicines. But frequently they carried out their activities in total isolation from each other, from other sectors, and from the population at large. This isolation hindered them from developing a vision of their role in disaster preparedness. Consequently, as late as the second half of the 1970s, health and water authorities could not find a rationale for including the topic of disaster preparedness in their activities. A typical reaction was, "Disasters? That's the responsibility of the military (or the civil defense, or the Red Cross) . . . . We have nothing to do with that." The earthquake in Guatemala was one of the experiences that most dramatically underscored the gulf, in normal times and in times of emergency, between the relief assistance experts and the institutions supplying health and water services. Each needed to understand its particular role in disaster preparedness and to expand its services from central urban areas to provincial and rural ones.

Most national civil defense systems expanded their organizations by setting up local civil defense committees. However, the dictates from a central bureaucracy on which they depended reflected their principal concerns: the maintenance of public order and safety in case of emergency. Although local committees gave the pretense of community participation, in practice they preserved their hierarchic centralized mode, thus preventing the participation of the principal protagonists, the members of the community at risk.

DISASTER PREPAREDNESS

Disaster preparedness includes all activities that are carried out prior to advance notice of a catastrophe to facilitate rescue, relief, and rehabilitation and to use the available resources in the best possible fashion—first at the local level; if these are insufficient, at the national level; and finally at the international level.

Source: PAHO/WHO.

Box 5.1

MEDICAL CARE AT THE DISASTER SITE—A VITAL LINK IN HEALTH SECTOR DISASTER PREPAREDNESS

Photo Gaggero, PAHO/WHO

Prehospital medical care plays a vital role in responding to major emergencies Treating massive numbers of victims in a disaster requires a well-coordinated interagency approach involving health personnel, search and rescue teams. first aid workers, fire fighters, police, and security forces Without a central coordinating body that maintains communication between rescue and relief efforts. chaos results

Timely medical treatment at the site of a disaster requires triage and tagging techniques to categorize and classify victims. To perform this work effectively, well-coordinated personnel (pre-hospital, hospital, and medical personnel; paramedical personnel, and other health care workers) trained in the management of mass victims is needed.

While initial efforts at developing these networks of personnel have been made in certain large cities, they have not been developed in most countries of the Region, due to the scarcity of people trained in prehospital treatment Most prehospital treatment is performed by volunteers affiliated with the Red Cross or by medical staff or assistants sent from hospitals close to the site of a disaster Strategic efforts aimed at strengthening prehospital treatment should constitute an important element of metropolitan disaster preparedness and response plans.

Source PAHO/WHO

THE DECENTRALIZED PHASE: PREPAREDNESS OF PUBLIC SECTORS AND THE COMMUNITY

In addition to planning by relief agencies, disaster preparedness requires the organization and participation of a country's institutions and the training of its human resources. Emergency preparedness must not be organized solely at the central level, but also with the participation of numerous other sectors: establishments such as schools. hospitals, blood banks, and airports also need plans (see Box 5 1). The success of these efforts has varied from country to country depending, to a great extent, on the amount of authority the coordinating agency responsible for emergencies has, and the harmonious relationship between the country's civilian and military sectors.

PREPAREDNESS AS A MULTISECTORAL TASK

Those countries in Latin America and the Caribbean that have improved their disaster preparedness demonstrate two prerequisites for success strong political support for national disaster agencies and solid coordination between sectors

From the outset, the health sector in Latin America and the Caribbean created awareness and assumed leadership to coordinate all members of society in developing preparedness policies that met their needs. Starting in 1977, with the support of PAHO/WHO. countries in the Region initiated a process that still continues; they set up disaster preparedness units in most Ministries of Health and designated focal points in each. This experience yielded an unprecedented

hoto above: raining for pre-hospi reatment is accom- lished through a sim ation exercise in Peri

technical and qualitative change in the Region. In a few years' time, the health sector's response capacity was changed so that it included other disaster preparedness organizations, governmental institutions, and national and international NGOs in its training, planning, and organizing.

The visible results of this process encouraged the countries to develop and improve their emergency plans and to exchange information and experiences Subregional and regional meetings promoted by the health sector provided a timely forum. These meetings have led to the establishment of many important disaster preparedness policies. One of the most notable is a regional policy on international disaster assistance (see Box 5.2). This policy was further strengthened by including the Ministries of Foreign Affairs in national preparedness plans. When disaster strikes, this sector, through its diplomatic and consular offices, plays an important role by encouraging donations and providing information on the kinds of donations needed from abroad Cooperation between the health and foreign affairs sectors has yielded common criteria for managing and coordinating international assistance, thereby reducing the potential for conflicting requests. As a final outcome, several Ministries of Foreign Affairs have designated focal points

Box 5.2

LATIN AMERICA AND THE CARIBBEAN SET REGIONAL POLICY ON INTERNATIONAL HEALTH RELIEF ASSISTANCE

The balance between the need for immediate international aid on the one hand, and the appropriateness of the donations on the other, is a delicate one. In disaster after disaster stories abound of containers of useless supplies, spoiled food, or medical supplies bearing instructions in foreign languages All of this competes for space and the immediate attention of the country s disaster managers.

The earthquake in Mexico in September 1985 was still in the headlines when, barely two months later, the volcanic eruption of the Nevado del Ruiz took place in Colombia After these traumatic disasters, high-level representatives of the governments of the Americas met in San José, Costa Rica, in March 1986 to make international health relief more compatible with the needs of affected communities. The recommendations made at this meeting—approved unanimously by the participants—became the formal regional policy of PAHO after ratification by the Ministers of Health of Latin America and the Caribbean at the XXXII Meeting of PAHO's Directing Council in 1987

This policy, to which all the countries in the Region have pledged to adhere, stipulates that:

- Donors will consult with the health authorities or with the appropriate agencies of an affected country before providing assistance.
- The affected countries will assess health needs quickly and communicate the needs to donors as soon as possible.
- Inasmuch as many countries in the Region are both recipients and donors of international relief assistance, all will establish policies regarding the acceptance of unrequested or inappropriate supplies

Source PAHO/WHO

Box 5.3

LEGISLATION ON DISASTER MANAGEMENT IN THE ANDEAN COUNTRIES

Legislation on disaster management in the Andean countries of South America goes back to the 1930s and 1940s, when responsibility for handling accidents, calamities, and epidemics was assigned to specialized relief organizations such as the Red Cross in Colombia, or the National Relief Board in Venezuela.

Starting in the 1960s, civil defense systems were established in Colombia (1965) Venezuela (1971), Peru (1972), Chile (1974), and Ecuador (1983) In the late 1980s new elements began to be integrated into the existing disaster management programs to regulate and coordinate the participation of the health sector with other sectors In Colombia, for example, legislation established the National System for Disaster Prevention and Response to define the responsibilities of all public, private, and community organizations In 1989 regulations for the National Health Committee for Emergencies (CONASE) were promulgated in Ecuador; and in 1992, the Advisory Council of the National Civil Defense System was set up in Peru.

The legislative framework for regulating disaster management is responsive to changing needs that have emerged in the countries For example, as a result of the Nevado del Ruiz tragedy in Colombia, emergency funds were set up to provide credits to disaster victims, and grant tax exemptions for the importation of machinery and equipment. In Ecuador, the National Office for Fire Protection was organized by the Ministry of Social Welfare to guarantee enforcement of related legislation. In 1989 the Drought Emergency Program was organized in Peru to manage external funds obtained by the government through technical cooperation assistance. Another example of legislation includes the Permanent Presidential Commission, established by Venezuela in 1990 to develop contingency plans for flood control on the eastern coast of Lake Maracaibo.

Source PAHO/WHO

responsible for disaster preparedness activities, thus ensuring their continuity Chile, Colombia, Ecuador, Jamaica, and Panama, among others, have also published and distributed guidelines and procedures for their diplomatic and consular missions.

LEGAL EVOLUTION OF DISASTER PREPAREDNESS

A problem today in many Ministries and State institutions active in disaster preparedness is that they have neither legal status nor a fixed budget, although from time to time additional resources are mobilized on an ad hoc basis (see Box 5.3). The situation in the health sector illustrates this problem Although all the countries in the Region have established a health sector disaster preparedness program, fewer than half the programs in Latin America have legal backing with specific resources earmarked for this purpose in their national budgets. The laws that do exist are often incomplete; without high-level political support, the authority delegated to the disaster preparedness unit is weakened

Until the 1980s, laws existed to support almost exclusively the activities of the civil defense agencies Subsequently, more comprehensive laws were adopted at the national level that extended to the public and private sectors. These laws led to the creation, for example, of the Comisión Nacional de Emergencias (National Emergency Commission–CNE) in Costa Rica, the Sistema Nacional para la Prevención y Atención a los Desastres (National System for Disaster Prevention and Response–SNPAD) in Colombia, the Disaster Pre-

paredness Offices in Barbados (CERO), and the National Emergency Management Agency (NEMA) in Trinidad and Tobago which have separate funding, and special authority during officially declared emergency situations. The Jamaica legislature recently empowered the Office of Disaster Preparedness and Emergency Mangement (ODPEM)to raise its own funds and to mobilize national resources toward preparedness.

These national trends reflect the strengthening of democratic institutions. They also ensure the participation of the public and private sectors, together with the security forces, in their respective areas of responsibility and expertise. However, laws also have their limitations, since they cannot absolutely provide for every eventuality. They may even limit the authorities' ability to respond in a flexible manner to the events, and force them to step outside the legal framework to approve actions on an ad hoc basis. For this reason, countries must strike a balance between the flexibility needed for responding to disasters and the legal basis that supports them.

COMMUNITY ORGANIZATION

In the 1980s, at the same time that the Region's nations were strengthening their institutions, local communities were becoming increasingly involved in disaster preparedness activities. Assistance, whether national or international, often arrives hours or days after the catastrophe, too late to make a difference in saving lives. The local population is in the best position to understand its own environment and culture and consequently is able to provide not only a quicker, but a more adequate response to disasters. Box 5.4 describes projects in El Salvador and Peru that communities undertook to deal with disaster situations and reduce their vulnerability. These projects also served to solve day-to-day problems of development, thereby benefiting community organization. Similar projects were undertaken in marginal neighborhoods of Santo Domingo in the Dominican Republic.

In the 1980s in Central America some 2 million people in Guatemala, El Salvador, and Nicaragua fled their homes as a result of civil strife. In 1990, Belize, Costa Rica, El Salvador, Guatemala, Honduras, and Nicaragua initiated PRODERE (Programa de Desarrollo Regional), a development program for displaced, refugee, and repatriated persons in Central America. This program, supported by the Government of Italy, involved the participation of almost all UN organizations under the coordination of UNDP and several NGOs.

PRODERE offers vulnerability analysis in the face of natural, chemical, and environmental hazards, including the prevention and management of disasters. It also demonstrates the interrelationship between rehabilitation after a disaster or in a "complex" emergency (one brought on by civil strife), sustainable community development and preparedness for natural disasters.

Preparedness experiences in small communities in Latin America and the Caribbean demonstrate that to be motivated to prepare for disasters, people must be convinced that reducing their vulnerability contributes to the overall development of the community, since disasters only worsen the day-to-day problems of poverty and underdevelopment. In small communities the lesson was learned that it is not possible to consider the link between disasters on the one hand and health on the other, without

Photo: Gaggero, PAHO/WHO

The local population is in the best position to understand its own environment and culture and consequently is able to provide not only a quicker, but a more adequate response to disasters.