Panel 2.7: First 30 Days: Organizing Rapid Responses

Ms. Natacha Emerson (Chair);[1] Dr. Arturo Pesigan (Rapporteur);[2] Dr. Lita Sarana (Panelist 1);[3] Dr. Nenette Motus (Panelist 2);[4] Dr. Dan Buriak (Panelist 3);[5] Dr. Tim Randall (Discussant)[6]

1. Humanitarian and Emergency AUSAID
2. Regional Adviser, World Health Organization/Western Pacific Region
3. Indonesian Red Cross
4. International Organization for Migration (IOM), Banda Aceh, Indonesia
5. Director of Supply Chain Management, Pfizer, Inc.
6. Senior Research Officer, UK Defense Academy, Cranfield University, Shrivenham, Swindon, United Kingdom

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Abbreviations:
UN = United Nations
WHO = World Health Organization

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Abstract

This is a summary of the presentations and discussion of Panel 2.7, First 30 Days: Organizing Rapid Response of the Conference, *Health Aspects of the Tsunami Disaster in Asia*, convened by the World Health Organization (WHO) in Phuket, Thailand, 04–06 May 2005. The topics discussed included issues related to organizing rapid responses as pertain to the responses to the damage created by the Tsunami. It is presented in the following major sections: (1) issues; (2) key questions; and (3) recommendations.

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Background

The Tsunami's magnitude posed a great challenge to humanitarian and public health actors. Major factors included: (1) the emergency affected many countries simultaneously; (2) it occurred during the holiday season; and (3) many health disaster experts already were fielded in other crisis situations around the globe.

A positive aspect to the responses to the Asian Tsunami was the outpouring of support, including financial, material, and human resources. In the affected areas, the community, government, national organizations, and locally based international organizations were challenged to respond to the acute emergency and also to absorb the national and international support coming into the area.

During the acute phase of response, there was an overwhelming deluge of consultants and volunteers in the sites. Despite the good intentions of certain groups and individuals, concerns were expressed in the quantity and quality of recruited consultants. Furthermore, there also were concerns as to the significance of teams or volunteers who would only stay in the field for a few days.

The session discussed first-hand experiences on how agencies and organizations responded during the first 30 days.

Issues

Some of the issues raised during the rapid responses to the disaster included: (1) "golden" period for response; (2) communications; (3) logistics; (4) rapid health assessments—methodologies and timing; (5) significance of situation reports; (6) setting-up an operations center; (7) decision-making and accountability; (8) essential public health functions; (9) risk communication; (10) public information; (11) preparedness issues—protocol for emergency response; (12) staffing/personnel issues; (13) field deployment of staff; (14) management of volunteers; (15) ethical issues on aid and health/medical practice in the affected countries; and (16) sensitivity to national culture, health practices, and existing health systems.

Key Questions

1. What initial steps were taken as soon as the communication was received that the event had occurred? Who was notified first? How

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was accuracy of the information received verified? How was the first health team deployed? What was the composition of the first team? What supplies, equipment, and materials did the team take with it? What communications equipment did the first team bring? How was travel arranged? How soon was a team deployed and how soon did the team arrive at the site?

2. In fielding health teams, what set of criteria was used in choosing team members and recruiting consultants? What kind of orientation was given to them by the sending and receiving agencies? How were teams or consultants that stayed in the field for a very short period of time (i.e., a few days) dealt with? What is the optimal time length of stay for volunteers and technical support teams during the acute phase of response? What problems were encountered in making administrative arrangements and preparations for fielding health personnel? How was continuity of services ensured?
3. How were volunteers managed? What kind of policy should be developed for good volunteerism practices?
4. How was an agency operations center (agency-based and field office) set up? What were the essential components of the center?
5. What were the challenges in setting up the field office? Who was in charge of communications? How adequate was logistics and supplies management?
6. In planning for emergency interventions, to what extent were the national counterparts involved in decision-making? How can it be ensured that interventions and activities are nationally driven?
7. In conducting the initial assessments, what challenges were encountered regarding information sources, actual collection and collation of data, and dissemination of information? What are the best avenues for information transmission?
8. What are the essential public health functions that should be provided during the first 30 days? What measures were taken to ensure that services reached the most vulnerable populations?
9. What mechanisms were in place for managing donations? How were the guidelines on donations of medicines observed by the donor community? How were donations tracked, and what mechanism was established to ensure effective distribution of donations to the most in need?
10. To ensure the best practices for interventions in health, what mechanism can ensure quality control? What coordination mechanism was set up to facilitate information, ensure quality services, and prevent duplication of services?
11. Is it possible to have a "prescription" as to the day-to-day sequence of actions to be taken for the first 30 days? What are the elements of the essential activities for the first 30 days?
12. When is the acute phase over?

Observation

Some three months into the emergency, there still were stricken communities in Aceh Province, Indonesia that did not know how to gain assistance.

Discussion

Issues

The first responses to an event are provided by local members of the communities and national governments. It is worth noting whether the national contingency plans existed for events such as the Earthquake and Tsunami of 26 December 2004. If contingency plans existed, were they effectively and efficiently applied during the first responses?

Have any of the affected countries committed themselves to reviewing their contingency plans, and what is being done by the international community to assist them in this process?

Although the provision of information is the responsibility of the State, how could the United Nations (UN) have assisted to ensure that such situations did not arise? For example, was public information included in the initial response, and how was this amalgamated with other sectors and recipient nations?

Bearing in mind the continual seismic risks that exist in the region, how did the World Health Organization (WHO) incorporate mitigation and preparedness into its initial response? For example, did the WHO use structural engineers to evaluate the safety of medical facilities so that they might be repaired and strengthened before re-occupation and use? Did they just accept the buildings and structures without evaluation by competent structural engineers? If used, did existing buildings sustain further damage?

From the private sector perspective, key issues in organizing a rapid health sector response to disasters:

1. *Money*—early commitments and unearmarked funding;
2. *Medicine*—the identification and provision of relevant supplies according to WHO guidelines;
3. *Minds*—the deployment of experts with the appropriate technical skills who have undergone rapid response training and who comprehend the essentials of humanitarian practice;
4. *Manpower*—surge capacity during the initial phases and ensuring personnel are given clear tasks and focal points with key partners and host government are established to enhance coordination in the response system; and
5. *Mechanisms*—setting up systems and procedures during the early phases to ensure the right resources go to the right places when needed.

Lessons learned

Key lessons learned concerning organizing a response to disaster and during the first 30 days include: (1) empowering national governments and communities is needed; (2) command and control are necessary, but not mutually exclusive; (3) it may be helpful to develop clear, simple health messages that should be shared with media before an event so that they can be disseminated immediately if and when an emergency occurs; (4) building the capacity of

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the public health system and practices during the early response phase is crucial for the sustainability of adequate health practices for use in the long-term. Additionally, supporting the decision-making role and collaborating with all levels of the host government's Ministry of Health ensures that connectedness with local communities and downstream measures are at the epicenter of the emergency response; and (5) psychosocial support to humanitarian health workers (both national and international) is important to ensure productivity and greater continuity of staff.

Recommendations

1. *Effective coordination* in order to avoid overlap and identify the gaps in the humanitarian response system. This also requires monitoring to ensure that coordination leads to decision-making and implementation.
2. *Information management* is needed to disseminate information to humanitarian response actors in order to make informed decisions on how to allocate their funds and respond to the most pressing needs. Information management also is needed to provide public information so as beneficiaries also are aware of where they can get assistance and the various options that are open to them as victims of the disaster.
3. Preparedness includes *preparing reporting formats* so that collected and collated data are useful for decision-making. One example is gender-aggregated data to identify the specific health needs of women.
4. Finally, the most important part of disaster response is *disaster preparedness*. Establishing standard operating procedures and clear, practical guidelines for communications and operations are crucial to respond effectively to emergencies. National governments and organizations responding to disasters should set up mechanisms to activate systems swiftly and to train their staff on these operating procedures.

Summary

Their were many issues raised during the rapid responses to the disasters that followed the Earthquake and Tsunami. Included in the lessons learned are: (1) the need for the organization and empowerment of coordination and control; (2) establishing and maintaining relationships with the media; (3) building the capacity of public health systems; and (4) the provision of competent psychosocial support mechanisms. Responses should be directed at enhancing preparedness, improved and enforced coordination structures; and better informatin management systems.

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