What Have We Learned? Coordination

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Keywords: best practice; civil-military; control; coordination; crises; disaster; donors; education; governments; inter-governmental organization (IGO); national capacities; non-governmental organization (NGO); preparedness; private sector; recovery; responses; standards; training; World Health Organization (WHO)

Abbreviations:
MOH = Ministry of Health
MOU = memorandum of understanding
NGO = non-governmental organization
OCHA = UN Office for the Coordination of Humanitarian Affairs
UN = United Nations
UNHCR = United Nations High Commissioner for Refugees
UNICEF = United Nations' Children's Fund
VSAT = very small aperture terminal
WHO = World Health Organization

Web publication: 17 November 2005

Abstract

This paper outlines each aspect of coordination as it relates to the responses made by various organizations in the disaster-affected areas. It is a synthesis of the presentations and discussions pertaining to coordination during the Conference, *Health Aspects of the Tsunami Disaster in Asia*, convened by the World Health Organization (WHO), in Phuket, Thailand, 04–06 May 2005. Coordination is defined, and two important questions are answered: (1) What coordination was done well?; and (2) What coordination could have been done better?

Oyegbite K: What have we learned?—Coordination. *Prehosp Disast Med* 2005;20(6):471–474.

Introduction

Merriam-Webster Online Dictionary defines coordination as, "the harmonious functioning of parts for effective results." Some participants helped to define coordination as: (1) allocating tasks to maximize complementarity, harmonizing procedures, and planning strategies; (2) channeling efforts of all of the actors to achieve a common goal (e.g., a symphony orchestra); and (3) akin to leadership, i.e., getting things done through people or, in this case of an emergency event, other organizations.

The elements that require coordination in the health sector include, but are not limited to: (1) efforts by the affected community; (2) national and local governments activities in the affected areas; (3) donor governments (bilaterals); (4) multi-lateral agencies (including the United Nations (UN) and international financial institutions); (5) national and international non-governmental organizations (NGOs); (6) academic institutions; (7) the military; and (8) the media (Table 1).

Should the World Health Organization (WHO) coordinate these activities during a disaster or crisis response? National governments, especially the Ministries of Health (MOHs), should provide the coordination of the health responses. It is a primary responsibility of national governments to coordinate all of the responses to an emergency in their respective countries. In places in which structures of government exist and are strong, this has been done well; the World Health Organization (WHO) often supports these efforts in the health sector as necessary, especially in bringing knowledge and materials that might not be available locally. However, in areas in which the national government has failed during a conflict, the WHO might take a leadership role in health sector coordination to guarantee a minimum standard of health care for the victims.

The roles of the Coordinating Body responsible for the medical care and public health functions are to (Table 2):

1. Work with all of the actors to establish and agree to norms and standards, e.g., on the subject of the response;
2. Lead in the emergency preparedness planning and drills;
3. Actively engage with the other actors within the sector, sharing information as it becomes available;

- Affected community
- Governments
  - Local
  - National
  - Donor (bilateral)
- Multi-lateral agencies
  - Inter-governmental (United Nations)
  - International financial institutions
- Non-governmental organizations
  - National
  - International
- Academic institutions
- Military
- Media

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Table 1—Health sector actors requiring coordination

4. Integrate health expertise and activities for maximum effectiveness and efficiency; and
5. Acknowledge the roles of all of the actors, i.e., giving credit to whom it is due during the response.

What Was Done Well?

Several aspects of the coordination of the responses seem to have been done well. These included, but are not limited to, the following:

1. *Resilience of communities affected*—Participants felt that most of the affected communities have faced similar incidents in the past, even if smaller in scope, and as a result have developed some coping mechanisms and resilience, which was helpful in the immediate aftermath of the event;
2. *Strength or capacity of national governments affected*—The capacities of governments were recognized, particularly in India, Thailand, and Sri Lanka; this strength bolstered the health sector responses and decreased the time it took to return to the pre-event status in the sector;
3. *Immediate and prompt response*—The national and international responses were judged by participants to be prompt in all of the countries affected; these prompt responses mitigated the effects of this event, even as the final death toll was undetermined;
4. *The WHO's Health Mandate was utilized effectively*—The mandate of the WHO as the lead agency in several of the affected countries helped the WHO become recognized as the lead health agency;
5. *Credibility and strength of the coordinator*—Because the WHO already had a presence in each of the affected countries, and had developed good working relationships with the partners in the sector, it was not complicated for the WHO to enter and support the efforts of the national governments in sector coordination;
6. *Agreement of common goals*—Because of the magnitude of the disaster, there was no time for arguments among the health agencies about their roles; everyone wanted to continue with the work;
7. *Collegiality*—Rather than command and control, coordination characterized the relationships between the governments, the WHO, and other agencies;
8. *Disaster preparedness of participating agencies with predefined roles*—Except for the Maldives, most health agencies had worked previously in emergency responses with the WHO. There was an unwritten set of rules, and each party knew what to expect;
9. *Speed of mobilization of assets and other resources (personnel, material, financial)*—The prompt mobilization of resources, especially by national and foreign militaries, was unprecedented, and thus, set a new standard in humanitarian response; and
10. *Some examples of excellent cooperation worthy of emulation have been reported to have occurred among UN agencies*—For example, the WHO installed a common, service-ready, very small aperture terminal (VSAT) in Meulaboh, which was shared with other agencies. The United Nations' Children's Fund (UNICEF) agreed to coordinate the sharing and maintenance of this facility, including installation and operation of any inter-agency wireless connections. Also, the United Nations High Commissioner for Refugees (UNHCR) established common calling frequencies.

1. Establish norms and standards
2. Lead preparedness activities
3. Share information
4. Integrate expertise
5. Acknowledge roles

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Table 2—Roles of coordination

- Open communications
- Information sharing
- Type of emergency
- Scope
- Flag-posting
- Sovereignty
- Multiple agencies/actors
- Emotions
- Rapid turnover
- Languages
- Competition
- Uniqueness

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Table 3—Challenges for coordination

Challenges for Coordination: What Could Have Been Done Better?

Although some of what was done in the coordination of responses went well, many activities could have been done better (Table 3). These included, but are not limited to:

1. *Open communication and prompt information sharing*—Data and information from the field were not shared widely between responders, who treated these data as their organizational property instead of common goods;
2. *Type of emergency and scale of disaster*—One event due to a natural hazard affecting approximately 10 countries within hours of each other is something the global community has not seen for some time, and thus, it was difficult to comprehend the total magnitude of the event. Therefore, the speed of responses was uneven in many of the affected countries;
3. *Credit claim by each actor: visibility or flag-posting*—Many organizations that provided one or more responses wanted to work independently. This resulted in repetition and wasted time and efforts, and was burdensome

1. Build national capacity
2. Enhance national/sub-national preparedness
3. Pre-assign tasks
4. Develop pre-event inventories
5. Empower coordination and control
6. Enhance victim identification process
7. Civil-military coordination
8. Integrate private sector
9. Collaboration between responders
10. Develop standards and norms
11. Plan recovery
12. Attend to special populations

Table 4—Conclusion and recommendations for improving coordination and control

to the recipient governments and communities. This is not a good precedent for future humanitarian responses to any crisis;

4. *Sovereignty of states*—Although states should take the lead and primarily are responsible for the welfare of their own people in times of crisis, no state is an island, and when needed, offers of assistance generally should not be refused on sovereign or political grounds. Refusals based on sovereignty or political grounds, and not on defined needs, could lead to the violation of the rights of individuals to health;
5. *Dealing with multiple agencies could be disruptive*—Especially in Sri Lanka, the Maldives, and Indonesia, dealing with multiple responders caused disruption to the efforts of local authorities trying to cope with a disaster;
6. *Emotions-based, not needs-based actions*—Actions of many agencies were based on emotions and not on needs, which resulted in anger, not just of the people immediately impacted by the disaster, but also by sympathizers, also proved to be a major challenge (e.g., sending of air freights of materials that are not needed or already are oversupplied, or that are culturally inappropriate in the affected area);
7. *Multiplicity of responders assessing the same things in the same places*—A good example of this is the multiple needs assessments that were conducted in the same communities. This often involved multiple interviews of the same people. This added unnecessary stress to people who already were traumatized. This especially was the case in the Maldives and Aceh, Indonesia;
8. *Rapid turnover of international and national staff, who came only for short assignments*—Professionalism must be brought into emergency responses. For example, in Aceh, it was common for national and international staff to come to the area to work for one week or less. By the time they built relationships, understood the situation, and could begin to contribute, they were on their way home ("disaster tourists");
9. *The labels of many supplies/drugs were written in languages that were not understood, and no prior information was available*—Although generosity was welcome, the Maldives is an example where drugs and other supplies arrived at the airport without notice and sometimes the labels were written in non-native languages. This was wasteful and frustrating;
10. *Competition*—Competition among donors led to inflation because agencies wanted to complete tasks rapidly. Given their limited resources, this competition resulted in raising local rates unduly, making it difficult for the government to contribute, e.g., in the Maldives; and
11. *Every crisis and each country is unique*—Some of the lessons learned from this experience cannot be transferred completely for different events and different countries. However, there are common characteristics of an emergency that allow some of the lessons learned to be applied in most situations.

Conclusions and Recommendations

Given the above observations, the following conclusions and recommendations are offered relative to the coordination of actions (Table 4):

1. *National capacity building*—Governments, assisted by the WHO, should accelerate investment in national capacity building. The Epidemiology Field Training Programme in Thailand is an example of "best practice" in this field that could be emulated by others;
2. *Preparedness*—Coordinated investment in the development of national and sub-national emergency preparedness with periodic reviews and updates and possibly practice drills by all concerned should be a priority for all governments. The WHO should advocate and facilitate this process. Disasters/crises may occur anywhere and at any time. Preparedness must include devising reporting formats so that the data collected and collated can be shared and used for decision-making by all;
3. *Pre-assignment of tasks*—In the planning of emergency preparedness, it is important to allocate tasks before any event occurs in order to maximize complementarity while harmonizing procedures—all of which will be important in the face of UN reform. For example, needs assessments preferably should be undertaken by teams that address a range of issues relevant to emergencies. They should include the areas of public health, nutrition, food security, water and environmental sanitation, mother and child health, and gender issues;
4. *Pre-event inventories*—Each country should inventory potentially needed resources for different types of emergency scenarios, including materials belonging to other agencies that are willing to give or lend them (including those from bilaterals and the private sector). The governments should negotiate acquisition of these assets before a disaster strikes;
5. *Legislation of power transfers*—There are some legislative processes required in order to empower actions in most countries. Where needed, it is essential that such legislative processes be accelerated, e.g.,

in the Maldives, Sri Lanka, and India, where legislative bills are pending;

6. *Victim identification*—Victim identification has become a major issue in disasters that involve massive numbers of fatalities. It is recommended that the forensic laboratory systems for victim identification be strengthened, as this was a major problem in most of the affected countries. The WHO is an agency that could take the lead in this process. It also is recommended that the WHO take the lead to convene a task force of experts to address the gaps in the current forensic processes;
7. *Civil-military cooperation*—The military has set a new standard for civil-military collaboration in emergencies against which future emergencies will be measured. It is recommended that the UN Office for the Coordination of Humanitarian Affairs (OCHA) identify neutral military institutions in other zones of the world and prepare them for emergencies. This preparation could be in the form of memoranda of understanding (MOUs) between two or more countries—a process that the OCHA could facilitate;
8. *Integration of the private sector*—The private commercial sector has become a major player in disaster preparedness, damage mitigation, responses, and recovery. These relationships between the private sector and governments and inter-governmental agencies should be cultivated. The WHO should promote and articulate the demand that all donors adhere to the well-established and existing guidelines for drug donations. New guidelines for other in-kind donations should be developed and existing guidelines modified to integrate the lessons learned from this disaster. It also is appropriate to develop guidelines for engagement of the larger, commercial, private sector;
9. *Collaboration*—There is a tendency to study only the organigram of other actors; there is much chemistry, but interpersonal relationships are not described in the organigrams, and must be fostered. Therefore, it is recommended that the WHO middle- and lower-level staff identify and develop working relationships with potential partners with common purposes well ahead of the occurrence of any emergency. However, each collaborating agency must be self-sufficient and not be a burden on others operating in the field;
10. *Development of standards and norms*—The content of health response still is unclear; this is an area in which the WHO should take the lead in establishing "best practice" standards and norms in consultation with its partners;
11. *Recovery planning*—Planning for the recovery of the health sector must be inclusive; it should be country-wide, systemic, owned by the country, and supported by all of the stakeholders;
12. *Special populations*—In addition to the fundamental challenges posed by displaced populations during an emergency, there are a number of marginalized groups in the affected countries, including illegal migrants and sex workers. The WHO should lead the effort in ensuring the rights of these people to health; and
13. *Coordination and control*—The experiences of Aceh and Sri Lanka have shown that if uncontrolled, numerous agencies can go to affected areas and work in total independence, often duplicating efforts and sometimes doing things that may be harmful (e.g., forced debriefing of stressful experiences). Efforts to control and coordinate such agencies must be expedited to ensure that this experience is not repeated. This will require the development of standards and specialized education and training programs for the responsible governmental agencies. The development and implementation of such programs should be facilitated by the WHO.

Summary

Although some of the responses to the 26 December 2004 Tsunami were well-coordinated, more must be done to improve responses to future disasters. Coordination and control during future disasters will require the performance of multiple tasks including the development of standards for best practice, education and training, enhanced preparedness, improved integration of the private and military sectors, improved forensic activities, and the provision of the mandate, power, and resources required for the performance of coordination and control.