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Session 3.2: How can we do better?
Measuring results of health interventions in disasters

Paul B. Spiegel MD, MPH

Slide 1 – Cover Slide

Slide 2 – Intro (30 sec)

The organisers of the conference have asked me to speak upon the topic of disasters in general, both natural and manmade, not just on the recent Tsunami. Furthermore, they have asked me to be provocative and critical. [actually, I’m not so sure about the critical part, but I am going to be anyway].

I have listened intently to the presenters discuss the assessments and responses that were and continue to be undertaken with respect to this devastating Tsunami.

“What has been is what will be, and what has been done is what will be done; there is nothing new under the sun”.

What I mean by this is that what needs to be done to improve the monitoring and evaluation of health interventions in disasters has been known for years. Lessons learned have been documented and then repeated, almost verbatim, in hundreds of evaluation reports over the past decade. Yet the same mistakes seem to be repeated disaster after disaster.

Slide 3 – Key Lessons Learned (60 sec)

How to do better is a much more difficult to question to answer than what needs to be done better. Clearly, we need to apply the previous lessons learned from other disaster and not just repeat the same mistakes. I have categorised the key lessons learned for health evaluations in disasters during the past decade into 5 major categories:

1. Improve coordination
2. Standardise methods and indicators
3. Ensure sufficient and appropriate baseline data
4. Provide appropriate technical expertise
5. Ensure more commitment and funds to act on recommendations
What I will present to you today is a summary of some of the key lessons learnt in evaluating the health response to major disasters over the past decade, with an emphasis on some unique aspects of the Tsunami. Besides my own experience and those of colleagues I have spoken to as well as important issues I have learned from this conference, a major source for this presentation has been the ALNAP\textsuperscript{a} website, which has a database of over 500 evaluative reports on natural and complex humanitarian disasters over the past decade.\textsuperscript{1} ALNAP stands for Active Learning Network for Accountability and Performance in Humanitarian Action. Finally, I will end with some recommendations on how we can do better.

Slide 4 – Multi-sectoral monitoring and evaluation (M&E) of health interventions (90 sec)

1. Physical
2. Psychological
3. Socioeconomic

The physical effects of the Tsunami have been enormous but time-limited. The mental and socioeconomic effects will be long lasting and likely intergenerational.\textsuperscript{2} However, mental health evaluations can be difficult due to lack of consensus on methodology, and culturally appropriate and sensitive tools and outcome indicators.\textsuperscript{3} Much work has already been undertaken on this issue, but much more needs to be done and consensus sought.

1. Natural disasters
2. Complex humanitarian emergencies
3. Communicable disease epidemics

There is an overlap during the same emergencies of natural disasters, complex humanitarian emergencies and communicable disease outbreaks that has not been sufficiently recognized.\textsuperscript{4} In the Asian Tsunami, Aceh and Sri Lanka are areas with ongoing armed conflict. In another area of the world, Southern Africa, AIDS is the emergency and it lowers the threshold for other disasters to occur.\textsuperscript{5}

In the future, as AIDS continues to devastate countries and the unknown effects of global warming cause more natural disasters and other unanticipated consequences, the field of humanitarian assistance and development will need to work together as never before. Therefore, there is a continued and urgent need to bridge the gap

\textsuperscript{a} Active Learning Network for Accountability and Performance in Humanitarian Action
between disaster response and development; both in terms of actors and funding mechanisms.

For definitions of health, monitoring and evaluation, see footnote.b

Slide 5- M&E at various levels and of different actors (90 sec)

Hierarchy of Evaluations
1. System-wide
2. Partial system
3. Single agency response
4. Single agency, single project

What is needed is ongoing monitoring and intermittent and focused evaluations. What is the feasibility of real-time evaluations? By this I mean collecting data on the ground and using it immediately for decision making. Given computer, satellite and communication technology, this is more and more becoming possible. I believe real-time evaluations can and should be done. But it requires coordination, cooperation, commitment and technical expertise among numerous actors that has not sufficiently existed in the past.

There have been very few system-wide and multi-staged evaluations of any major disasters. By system-wide, I mean evaluation of the response by the whole system- all actors and sectors. By multi-staged I refer to multiple stages of evaluation over time and geography according to numerous and different variables.

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b Health (WHO): “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

Monitoring (modified from Development Assistance Committee-DAC): Continuing function that uses systematic collection of data on specified indicators to provide information on an ongoing intervention of the extent of the progress and achievement of objectives.

Evaluation (modified from DAC): Systematic and objective assessment of an ongoing or completed project, programme or policy, its design, implementation and results. Aim is to determine relevance and fulfilment of objective, efficiency, effectiveness, impact and sustainability. 
The two most well known system-wide evaluations are the Rwanda conflict and genocide evaluation\(^7\) and the Hurricane Mitch evaluation; although neither were multi-year evaluations. After examining many of the evaluations listed in ALNAP, it is clear that the majority are based upon evaluations by donors and organisations for their own internal usage; most are not multi-sectoral, multi-agency or governmental, multi-staged or system-wide.

**Of different actors**
1. Governments
2. UN agencies
3. Other International agencies
4. NGOs, CBOs, faith-based organizations – local and international
5. Military
6. Donors – bilateral and multilateral
7. Affected communities

Given the depth and breadth of the tsunami crisis, what is the role for humanitarian NGOs? For example, MSF-B received donations for the Tsunami equal to its entire operations in Angola, Afghanistan, Liberia, Sudan and DRC combined. What can humanitarian agencies actually accomplish in the aftermath of the Tsunami that Western and Regional Governments cannot?\(^8\) On the other hand, in Aceh and Sri Lanka, many humanitarian agencies have more experience in operating in war-affected areas than do Governments and most UN agencies. Evaluations need to clearly examine and compare the effects of health interventions undertaken by the local populations themselves, as well as humanitarian and development NGOs, both national and international.

**Donors:**
There have been staggering amounts of funds pledged for the tsunami. That may have huge distortions on health systems. Where will these funds go to and how will they be used? Will UN agencies and other organisations pay higher salaries and thus lure away government health staff? Will donors restrict their funds to short-term programmes for humanitarian NGOs and long-term programmes for development agencies?

**Recommendation #1:** Intermittent system-wide multi-staged evaluations, spaced over the next 10 years, are needed to evaluate the Tsunami health response.

**Slide 6– Coordination, politics and commitment** (90 sec)
Other colleagues have and will talk about the essential factors of coordination and the detrimental effects that politics can have on coordination and health interventions. I will just mention a few points.

There has been concern regarding equitable distribution of relief in some of the conflict-affected areas.4

There have even been rival plans for evaluations and early warning systems.

This is nothing new – but it must change.

**Recommendation #2: A clearly identified, recognised and respected coordinating body that has the 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.**

After examining numerous evaluations of disasters over the past decade, it is clear that lessons learned are not often learned but rather identified- over and over again. A proper M&E system requires political and financial commitment by governments, donors and key organisations; not just to implement ongoing monitoring systems and to undertake evaluations but to **ACT** on the results of them.

How can we stop repeating the same mistakes? Can some type of international body or committee be created to enforce a proper response to and evaluation of disasters? Can such a body have the authority to discipline an organisation if “disaster malpractice” occurs? There will always be tension between the independence of governments and organisations to have the freedom to act as they see appropriate and the authority of an international body to regulate and discipline those who do not act according to accepted standards, and thus commit “disaster malpractice”.10 However, a serious discussion among the international community needs to occur on this issue.

Evaluation reports should not and must not be politicised. During the sanctions in Iraq before the war, the number of deaths among children seemed to grow and grow as each organisation came out with a higher number – most were based on poor or nonexistent methodology and were grossly exaggerated. Similar claims were made regarding the number of deaths that could occur post-Tsunami.
Slide 7 – Quantitative and qualitative methodologies (90 sec)
There needs to be an appropriate mix of qualitative and quantitative methods for M&E. Standardization of such methods to allow comparability is essential. We all know that a tremendous amount of time and funds have been wasted over the years due to poor M&E systems.
Once again, there were issues with undertaking basic acute malnutrition surveys and estimating mortality in the Tsunami crisis. Different measurements, methodologies and interpretations were used. Some organisations that did not have emergency experience were using growth charts to measure nutritional status. Much has been written on the need for proper training and implementation of nutrition and mortality surveys in disasters; but again, the lessons learned have not been implemented.11,12 There is a need for a central coordinating body for M&E that can coordinate where and who does M&E, review protocols, peer-review reports and act as a central repository.
Standardisation of relevant and measurable indicators according to the phase of disaster is essential. There have been some efforts to create such indicators in disasters, such as the Sphere Project, which provides minimum standards in disaster response13 and the SMARTc initiative. These are important initiatives. International acceptance of ‘some sort’ of standards and indicators, together with a means to enforce them, is needed in order for them to be effective.

Slide 8 - Baseline data (60 sec)
“Chance favours the prepared mind” –Louis Pasteur (1822-95)
In order to properly evaluate health interventions, baseline disaggregated data are essential. As we all know, this rarely exists. Most of the assessments I have heard presented at the conference have not used a denominator. Thus individual counts versus rates have been used. For the most part, except for some diseases of epidemic potential this is not useful. Methods exist to estimate population size among displaced populations and, however gross, should have been used.
Baseline data should be collected in the disaster preparedness phase. We need to ensure disaster preparedness plans have standardised assessment forms to ensure key data, disaggregated by appropriate categories, are collected in 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 M&E system. Due to some of the poor quality of the assessments, better assessments must be undertaken immediately to direct interventions and allow for proper M&E.

c Standardised Monitoring and Assessment of Relief and Transitions initiative.
Slide 9 – M&E means undertaking research (30 sec)
Research is often considered a bad word among some donors and governments. They feel that funds need to go directly towards the affected communities. However, research is essential in order to study the effectiveness of such interventions. People affected by disasters are particularly vulnerable, and thus, measures need to be put in place to ensure research is undertaken in an ethical manner. Finally, we must report on not just went ‘right’ but also what went ‘wrong’. I was very appreciative to hear the countries discuss their successes and failures during this conference. I hope that WHO will do the same in the future.

Slide 10 – Recommendations – Disaster in future (60 sec)
UNAIDS and other organisations working on HIV and AIDS have agreed upon the “Three Ones” key country principles. The three pillars of this initiative are:
1) One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners
2) One National AIDS Coordinating Authority with a broad based multi-sectoral mandate and 3) One agreed country level Monitoring and Evaluation System.

We can learn much from these three principles.

I propose a modification of these principles for Disaster prone countries:
1) One agreed upon disaster preparedness plan that takes into account baseline data needed for future M&E systems.
2) One designated Disaster Coordinating Authority with a broad based multi-sectoral mandate and
3) One agreed upon Monitoring and Evaluation System. There needs to be strong political and financial commitment to undertake and act upon short, medium and long term system-wide and multi-stage evaluations at least over a 10 year period by all actors involved in disaster response.

Finally, serious discussion needs to be undertaken regarding the accreditation of those who respond to disasters and the establishment of a peer regulating body for disaster organisations. Lawyers have bar associations and doctors have medical associations. Why does no such system exist for those who have the serious and lifesaving profession of responding to disasters? Without such a peer regulating body to enforce accepted
disaster response principles and indicators, and to have the authority to discipline organisations who fail to meet such standards, the usefulness of monitoring and evaluation systems and reports will continue to be limited.

References: