

# What Have We Learned? Capacity Building for Health Responses in Disasters

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sustainability; training

**Abbreviations:**

UNICEF = United Nations' Children's Fund  
WHO = World Health Organization

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**Abstract**

This is a synthesis of the presentations and discussions pertaining to Capacity Building for Health Responses in Disasters 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: (1) Specific goals; (2) Main focal areas, including available training programs, country-specific training programs, targeted technical assistance for training programs, certified training programs, and ensuring that funding is available for training; (3) What has been achieved in building capacity; (4) Challenges; (5) Where capacity building is needed; and (6) Conclusions and recommendations.

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**Introduction**

The concept of capacity building varies widely depending on operational and disciplinary perspectives. Discussions often lose focus due to differences in views regarding whose capacity must be developed and for what purpose. As a result, there has been a great deal of conceptual discussion without much action at almost any level. The broadness of the scope of capacity building, which can range from the capacity of the military to respond to the capacity of laboratories to undertake tests at the approved quality level, is due partly to the absence of clear policies and definitions as to what exactly capacity building will mean for an organization like the WHO and, to some extent, its partners. Without such specifics, financial investment in capacity building is unlikely to come about.

**Specific Goals of Capacity Building**

The aim of building the capacities of the health sector is not different from those in other sectors. They include: (1) autonomy and self-reliance; (2) local capacities; and (3) sustainability.

1. *Autonomy and self-reliance*—Recognition that autonomy and self-reliance for disaster responses and relief is a primary goal for all communities-at-risk. In this context, building the capacity of the local communities is the main strategy to accomplish this objective;
2. *Local capacities*—The second goal derives from the first. Relief and responses are known to be most effective when people in the local communities are well-trained and the community is well-prepared for disasters. It is these persons that are quickest on the ground and most familiar with local conditions. The efficiency and effectiveness of the responses are enhanced greatly by improving the capacity of the local health professionals. Effectiveness also is enhanced by improving skills of the international relief workers whose performance, although much improved, still requires adjustment; and
3. *Sustainability*—Skilled and well-trained, local personnel ensure sustainability of the health gains made or systems put in place. When the relief efforts stop, these personnel provide the affected community with long-term benefits.

- Autonomy
- Self-reliance
- Enhance at local level
- Sustainability

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**Table 1**—Goals of capacity building**Main Focal Areas**

Building capacity for health preparedness implies “getting communities or relief teams ready to respond”. This is quite different from developing the capacity of communities to undertake disaster prevention/mitigation activities that ideally are part of regular development programs. To establish a clear program that builds capacity at whichever level, these focal areas must be stated clearly and the activities (interventions) must be linked to related goals.

There are five elements recognized for building and sustaining human capacity in health preparedness for disasters and emergencies (Table 2):

1. *Making available simple and appropriate training programs on key competencies for response and relief monitoring*—these programs must include those directly involved in providing relief services (i.e., healthcare workers, veterinarians, nurses, midwives, medical officers) and those providing critical adjunct services (i.e., pharmacy, laboratory, transport, waste management, referral services);
2. *Designing country-specific approaches to training and human resource development*—most countries or regions have a distinct disaster and vulnerability profile and require specific strategies for human resource development according to the prevailing conditions and national priorities;
3. *Providing targeted, technical assistance for introducing training programs*—the WHO Collaborating Centers and other networks of expertise could provide essential catalyst support. Training packages in the public domain could facilitate ongoing expansion of training at the country and regional levels. To be most effective and practical, they must be in line with national disaster response plans and regulations;
4. *Developing training certification and quality control mechanisms*—Recognized degrees and diplomas from national and regional academic institutions would help to ensure the continuity and quality control essential for disaster relief personnel; and
5. *Ensuring the availability of sufficient funds for implementing training*—resource mobilization is difficult for capacity building initiatives. It is essential that an action plan with concrete products and goals be developed without which funding is unlikely.

**What Has Been Achieved**

During the last decade, humanitarian actors have been encouraged to partner with local institutions in all of their operations. These partnerships or “twinning” have an indirect effect in supporting and developing skills and competencies of local partners. There has been a surge in short, intensive courses in disaster management. The quality of

- Training for identified key competencies
- Country-specific approaches
- Targeted technical assistance
- Qualification and quality control
- Funding

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**Table 2**—Elements required for building and sustaining human capacity

these courses is variable, and they only produce small groups of trained persons who represent only a small contribution with regard to need.

There has been a remarkable development of standards, norms, tools, techniques, and kits (e.g., Sphere Project, WHO kits, and the UNICEF Handbook) that have been important enabling factors for better and more professional performance. The Good Humanitarian Donorship Initiative has taken on the challenge of improving the capacity of donors to allocate their resources better and to evaluate the performance of their fundees.

Generally, there has been an improvement in the professionalization of emergency relief during the last decade, which is testified by an increase in capacities without explicit policies.

**Challenges**

Today, we still are faced with the daunting task of how to get the district/community levels educated for improved disaster relief and response. This is the biggest challenge that faces national authorities who are responsible to provide the leadership role in this initiative. Secondly, capacity building concepts must be transformed into goals and actions. Unless there are developed a set of activities that lead towards a capacity building exercise, the concept will remain academic. Thirdly, all capacity building actions must be institutionalized into sustainable frameworks within the country or the international organizations.

**Where Capacity Building Activities Should Be Undertaken**

There are several activities that are likely to produce the greatest augmentation in the capacity for health responses to disasters (Table 3):

1. *Strengthening organizational and management capacities*—Possibly the most difficult area to be approached is the strengthening of the organizational and management capacities. These areas are difficult to change in any sector and even more so, for health response to disasters—a sporadic event that quickly is lost from the political memory;
2. *Human resource development*—Human resource development is the most effective measure for sustainability and cost-effectiveness. What is needed is not emergency health managers, but health managers who know emergencies;
3. *Leadership*—Leadership skills are key elements for successful capacity building. Leadership qualities quintessentially are a personal trait, and this does not seem to lend itself particularly to a fixed training intervention; and

- Strengthen organizational and management capacities
- Develop human resources
- Provide leadership
- Develop partnerships
- Establish networks

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**Table 3—Activities for capacity building**

4. *Partnerships and networking*—Partnerships and networking are promising channels and successful efforts in this direction already have been made by professional associations of nursing and veterinarians.

Staff members who are trained at international and national levels are recognized to be the sole barrier to improved capacity of the health sector to respond adequately. This will not be solved by *ad hoc* small courses run by various organizations for some years funded by insecure sources. The one cost-effective option is the institutionalization of health management in disasters within the standard curricula for all of the relevant disciplines. These include medicine, nursing, veterinary medicine, laboratory sciences, and paramedical aspects. This approach not only would ensure continuity over the years, but should be integrated within the budgetary framework of established

institutions, and therefore, reduce the fragility of disaster health training, currently dependent on yearly funding.

#### Conclusions and Recommendations

Some examples of activities that can be envisioned for building health capacity for disaster responses and management include:

1. Partnerships should be established between institutions within the region, between regional groups, and with centers outside the region. Networks have been very successful in providing support, exchanging information, and providing technical know-how;
2. On-line courses for educating and training local persons should be developed by academic institutions in collaboration with operational partners; and
3. Standardized curricula for training in health responses to emergencies endorsed by the WHO should be developed and implemented.

#### Summary

Capacity building for health responses is directed best at the local level. Such preparedness activities require the development and implementation of standardized curricula based on accepted standards adapted to the culture in which such capacities likely will be used.