

Public health, emergencies and the humanitarian impulse

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The global response to the tsunami disaster in south Asia on 26 December 2004 has been overwhelming. Approximately US\$ 6 billion have been pledged in aid by citizens and governments, and authorities have offered military assistance and debt relief (W1). This outpouring of goodwill reflects the universality of the humanitarian impulse: an innate, altruistic urge to assist fellow human beings who are suffering (W2), which the President of MSF International recently described as “a visceral and practical response of one human being to the suffering of another” (W3). Codified in most cultures and all major religions, it is also found in the secular principle of “humanity” to which so many humanitarian agencies subscribe (W4).

The strength of the humanitarian impulse can be affected by various factors, among them people’s closeness to the suffering (as the media brought the tsunami victims into our living rooms), the suddenness of the disaster, the number of victims, and the ease with which people can empathize with the victims (for example, the many western tourists). Natural disasters are also much more likely to elicit a humanitarian impulse than are civil wars, because the victims are seen as blameless. Finally, professional perspectives are also influential: clinical doctors and public health professionals are both driven by humanity, but the reaction of public health professionals is also mediated by population-based morbidity and mortality statistics — which leads to a different response.

The very strong humanitarian impulse to relieve the suffering of those affected by the tsunami was mainly very positive, but it may unfortunately have resulted in some undesirable side-effects. Much of the assistance was inappropriate, with health agencies not able to match their enormous resources to the modest immediate health needs of the victims. In some areas, the overabundance of outside helpers added to problems of coordination. For example, one agency working in Aceh, Indonesia,

reported that health agencies were conducting so many measles campaigns that some children were receiving up to four measles vaccinations without appropriate record-keeping.

Some of these problems could have been alleviated if relief actors and the general public had had a better understanding of the “myths of disasters”, as laid out by the Pan American Health Organization (PAHO) and WHO (5, W6). Myths such as “epidemics and plagues are inevitable after every disaster” and “dead bodies pose a health risk and cadavers are responsible for epidemics in natural disasters” have been challenged by PAHO and WHO for years, but disaster-response mechanisms have not changed in recognition of the fallacies. This was exemplified by the many reports of mass burials, which unnecessarily deprived people of the chance to properly identify and mourn their dead (7). In addition, more appreciation of the fact that flood disasters result in many deaths but few wounded would have led to a more informed and measured response by the medical relief community (W8).

Although some see the generous support to the tsunami disaster victims as a hopeful sign that other, less media-friendly emergencies can be tackled, most fear that the donations from governments and the public will limit the resources available to other “forgotten” emergency situations such as Darfur and northern Uganda (W9). In the Democratic Republic of the Congo, 3.8 million excess deaths have occurred in the last six years, and chronic under-funding continues (10). Millions of long, slow deaths from malnutrition and diseases do not stimulate the humanitarian impulse in the same way as do natural disasters.

It is likely that, once the planned evaluations of the response to the tsunami disaster have been made, recommendations will focus on better ways to channel the humanitarian impulse, such as improving coordination and making funding proportionate to need. The debate about the accreditation of

agencies — as a guarantee that only well-qualified agencies respond to disasters — has already flared up again (W11). Better fund-raising mechanisms may also be recommended, emulating for instance the Disaster Emergency Committee, a consortium of the main United Kingdom relief agencies (W12).

What can public health professionals do to channel the humanitarian impulse? One obvious answer is to step up on-going efforts to dispel the myths of disasters, by making technically sound information easily available to the media, the public, relief agencies, national governments and their disaster management committees. More research may also be warranted, not only to strengthen the evidence underpinning disaster response but also to find better ways to communicate the right information at the right time to the right audience. Finally, it is important to advocate for more equitable assistance to the “forgotten crises”. This will require better data collection, more emphasis on sectorwide evaluations, more health services research into improved interventions in fragile states, and better communication regarding the impact of these crises on vulnerable populations. Together, these actions will enable the public health community to ensure that the principle of humanity is matched with its equally important counterpart, the principle of impartiality. ■

References

(References prefixed “W” appear in the web version only, available from www.who.int/bulletin)

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