

Groundbreaking approach to disaster relief

The humanitarian response to Cyclone Nargis, which struck Myanmar on 2 and 3 May, heralds a fundamentally new approach to relief coordination. As a result, a unique survey showed what really happened to the survivors. Sarah Cumberland reports.

Dr Rudi Coninx had just finished training on coordinating emergency relief efforts when he was summoned by WHO Director-General Dr Margaret Chan to join her at a teleconference. A devastating cyclone had just struck Myanmar. More than two million people were believed to be affected across the Ayeyarwady delta and Yangon regions.

“I was the only one from WHO headquarters in Geneva who could go because I happened to have a current visa,” says Coninx, who was despatched to Myanmar the following day to coordinate health relief in the stricken region.

“Technical and administrative units in the south-east Asia office of WHO worked almost round the clock, drawing experience from the tsunami,” says Dr Poonam Khetrupal Singh, deputy regional director for WHO Regional Office for South-East Asia (SEARO).

Meanwhile, staff from the World Health Organization (WHO) Country Office in Myanmar were already putting a new system into action with other United Nations (UN) agencies and nongovernmental organizations (NGOs) that were present. First, WHO convened the agencies providing health relief – known as the “health cluster” – to assess the situation and decide which health interventions were needed to prevent death and disease.

The “cluster” approach – the idea that a group of relevant UN agencies and others coordinate specific areas in an emergency response – is the result of recent UN reforms. “The tsunami of 2004 made clear the need for a coordinated approach that is predictable, accountable to donors and doesn’t duplicate the efforts of different organizations,” says Coninx.

WHO co-chaired the Myanmar health cluster with United Kingdom-based charity Merlin. “This relationship was extremely beneficial as it allowed

for the sharing of staff, technical and strategic expertise and the administrative burden,” says Yves-Kim Creac’h, head of Merlin’s Emergency Response Team.

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Unlike previous humanitarian responses by multiple agencies, the cluster approach meant that all UN agencies and partners, such as Save the Children and World Vision, worked together to share information and resources with agreed common goals.

“When I visited Aceh after the tsunami, there were about 300 NGOs but coordination was an issue,” says

Poonam Singh. “A lot of supplies were delivered that weren’t needed and there was a huge logistics overlap. This time there was a platform to bring everyone together as a combined effort.”

Coninx adds: “In Myanmar, when an aeroplane landed with medical supplies, we could make it known among the [members of the health] cluster what was available and allocate resources to underserved areas.” As the extent of the disaster and the health needs of the people in the stricken region became clear, the collaborative effort gathered momentum. Each week more organizations joined the cluster voluntarily, until more than 40 partners were meeting twice a week to pursue a single plan of action.

When responding to disasters, it is vital to have reliable information on the health needs of the survivors. “The first thing that needs to be done to provide relief is to find out what is really happening,” says Coninx. As with many disasters, an early warning system for epidemics was needed in Myanmar. This involved a daily



WHO staff demonstrate water sanitation techniques to the voluntary and community health workers following Cyclone Nargis. The provision of safe drinking water is a high priority immediately following natural disasters.

WHO (Myanmar)

exchange of information between these agencies to compare reports of outbreaks and verify those reports. For example, they confirmed that there was no cholera epidemic, but that the number of cases was only slightly higher than it was before the disaster.

Poonam Singh who visited Myanmar after the cyclone says that, despite negative media reports, the government was actually doing quite a lot to meet the health needs of the people. “Because of WHO’s long relationship with the Ministry of Health, we were looked upon a little differently by the government. Right from the beginning, the WHO representative to Myanmar [Professor Adik Wibowo] met every morning with the health ministry and we managed to get around the visa restrictions by recruiting locals, including retired WHO staff.”

Having just established its first health emergency fund through the contribution of US\$ 1 million by its 11 Member States, SEARO was able to release US\$ 350 000 to buy essential supplies such as health kits, mosquito nets and chlorination tablets. However, a larger relief operation was still being hampered because the government would not provide visas for additional relief workers and was imposing strict control over access to information on the incidence of diseases and suspected outbreaks.

Dr Nihal Singh, from the WHO office in Myanmar, said that this was perhaps because the Ministry of Health was not clear on the “concept”



UN Photo/Evan Schneider

United Nations Secretary-General Ban Ki-moon (in white jacket) speaks with survivors of Cyclone Nargis at a camp of internally displaced persons in the township of Bebaye, Myanmar.

of the health cluster and did not feel comfortable working directly with the UN agencies and NGOs.

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Dr Richard Garfield

Then, Dr Surin Pitsuwan, Secretary-General of the Association of Southeast Asian Nations (ASEAN), stepped in. After negotiating with

government officials, the turning point came on 21 May – three weeks after the cyclone struck – when the government agreed to accept international assistance and to collaborate with ASEAN and the UN in a unified approach. “We had to be careful not to politicize the situation,” said Dr Anish Kumar Roy, special representative of the ASEAN Secretary-General.

Senior officials from the country’s Ministry of Health began to participate in health cluster meetings, sharing data and providing assistance, and the government allowed open access to the entire stricken area to do a survey to assess health needs.

The unique political situation and the lack of existing data meant that donors demanded even more information and accountability than usual, resulting in what has been considered the most comprehensive survey ever conducted after a disaster.

In just one month, a surveillance team of 225 people, including 50 volunteers, travelled across the affected area to interview about 3000 households and conduct 1000 specialized interviews with village leaders, housewives, farmers and health workers. The survey used a grid to select a sample of almost 300 villages from a total of 6000 so that it was a truly representative assessment. Due to flooding many villages were cut off and had to be reached by helicopter or boat.

“We’ve never had an emergency situation where we’ve gathered such good data,” says Dr Richard Garfield,



UN Photo/Evan Schneider

A United Nations High Commissioner for Refugees (UNHCR) aid worker distributes blankets to the survivors displaced by Cyclone Nargis in Yangon, Myanmar.

from WHO's Health and Nutrition Tracking Service, who managed the surveillance team. "We had one guy who came in off the street as a volunteer and he turned out to be one of our best people. You really see what some people are capable of in an emergency."

Garfield says that surveys held after previous disasters have mainly measured aid provided. How many people received goods? How many villages were visited? For the first time, Garfield says, this survey asked questions to compare conditions before and after the cyclone. What kind of sanitation was in use? How far did people have to travel to seek health care? What kind of health problems did they have?

Some results were surprising, with most common health problems being diarrhoea and the common cold rather than the trauma and injuries that had been predicted. "We were expecting dramatic injuries but there were far fewer deep wounds caused by the cyclone than the Asian tsunami, where waves had a much greater force. A further surprising result was that the greatest health need was psychological support," says Garfield.

The survey revealed that twice as many women as men died during the cyclone, many falling into the flood

Fact file: Cyclone Nargis

Dead: 84 537

Missing: 53 836

Medical supplies dispatched by WHO and health cluster partners: more than 500 metric tonnes, including:

- 33 000 insecticide-treated bed nets
- 500 dengue fever disease kits to detect and confirm cases
- 30 000 surgical masks and gloves

Funds supplied immediately:

- US\$ 350 000 from SEARO's new emergency health fund
- US\$ 50 000 from WHO headquarters

Total needed to rebuild health facilities (75% of which were damaged or destroyed): US\$ 2 billion

waters since they were unable to clutch on to the trees for as long as the men. Other women died trying to save their children.

The data are being used to closely monitor recovery and reconstruction in Myanmar and will assist future relief efforts. "We don't usually have the information that permits us to answer questions such as: What difference did we make? How well did people recover? With this survey, we will be able to know when people get back to normal."

Work is already under way to develop this survey as a model for future relief efforts and to prepare a bank of

potential questions for different kinds of disasters.

Dr Eric Laroche, assistant director-general for the Health Action in Crises cluster at WHO, wants the Organization to strengthen its operational role in relief efforts by taking the lead on the ground, as it did in Myanmar.

"Some people say that WHO shouldn't be focusing on operational work," he says. "But that would be denying our historical role. WHO will be remembered for eradicating smallpox and for our anti-tobacco campaign, both of which assumed very much operational roles." ■

Nigeria still searching for right formula

Despite several attempts at reform over the past 30 years, Nigeria still lacks a clear and coordinated approach to primary health care. Michael Reid reports.

In 1990, Michael Asuzu held high hopes for the development in Nigeria of a primary health care (PHC) system based on community participation, using well-trained, well-equipped and motivated community health professionals.

Writing in the March 1990 issue of *World health* magazine, Asuzu, at the time a lecturer and consultant in the Department of Preventive and Social Medicine at the University College Hospital in Ibadan, enthused about a "bottom-up" grassroots PHC project in the hamlet of Elesu, 32 kilometres north of Ibadan. Members of Asuzu's university department had helped villagers develop a programme to control outbreaks of waterborne guinea-worm disease and adopt other PHC measures.

"We expect to be able to replicate this programme in any local community ready to take charge of its needs for PHC as the Elesu community has," he said. "This case history shows that, when community health development workers are available and willing to go out and assist communities, it is possible for them to come forward to request and be helped to provide community-owned and self-reliant PHC programmes for themselves."

Fast forward 18 years and Asuzu, now professor of Public Health and Community Medicine at the University of Ibadan, is less ebullient when discussing PHC in his country.

Addressing the Nigerian Academy of Science Seminar in Abuja in May this year, Asuzu said: "Nigeria has never

succeeded in establishing community medical and health services for very many reasons ... some limited levels [have] been practised in Nigeria, even during the colonial days, but never fully."

In June, Asuzu told the Nigerian Medical Students Association that Nigeria had in the mid-1980s joined the international push for PHC after the 1978 Alma-Ata Declaration of 'health for all'. "Some progress seemed to have been made with the health services between then and the mid-1990s," he said. "However, the health indices have been deteriorating since then [judging] by every health system evaluation [carried out] in the country. Unfortunately, Nigeria has never learnt or developed any system of authentic and full-scale community health care before Alma-Ata or after it. This explains why we have not made any success of the system."

The world health report 2000 ranked Nigeria 187 out of 191 countries for health service performance, a