Reconstruction of Relief:

A comparative review of health services in emergencies

WHO Conference on Health Aspects of Tsunami Disaster in Asia

Phuket, Thailand
4–6 May 2005
Focus on things that are not done well, and need attention in humanitarian relief systems.
Dispute the over-use application of the words “unprecedented” or “unique”

Focus on systematic approaches to reducing death and suffering in the future
Introduction

Current review:
United Nations (UN) response to the Tsunami comparing with govt’s and NGOs
Numerous UN re-invention issues will be debated this Summer/Fall
UN agencies and programs have their own mandates and governors.
Congressperson Frank Wolf

United States Institute of Peace
USIP Task Force on the UN

To be given to US Congress next month

to allow time for consideration Before the big September debates over UN reform
Our team conducted dozens of interviews and document review in Indonesia, looking at UN’s work in Aceh.
“right to life”
a responsibility to protect (?)
December 26
an earthquake struck unexpectedly

Tens of thousands killed instantly

search and rescue largely called off by dec 29

Need for coordination among all the aid agencies
United Nations Disaster Assessment and Coordination (UNDAC)
Bam, southern Iran 2003

• 30 - 40,000 deaths in brief period
• Two homeless for every person killed
• Failure to meet Sphere standards in shelter during recovery
• Bottlenecks on access and absorptive capacity
Two years earlier, also on the 26th (of January) the earthquake Gujarat India killed 20,000 –

- 166,000 injured
- Rate of injury 8 times the rate of death among physically exposed
Earthquake led to widespread fire, 1906 San Francisco
Quakes’ impact under sea can create tidal waves
Papua New Guinea

- Tsunami also created by under-sea quake
Fall 2004

• Charley, Frances, Ivan, Jeane killed thousands in Haiti, billions of dollars of damage.

• Reminiscent of Hurricane Mitch in 1998
Rescue is performed almost entirely by local people and groups.
In many larger emergencies, international resources did not reach the emergency-affected population in time

• As a result, several million died in Somalia, Ethiopia, Cambodia, Rwanda, Liberia, Angola, DRC, etc.
Some lives are saved

Aid agencies ramp up operations

Resources begin to be mobilized

News media Takes notice

Most big donations Donor commitments Are made

Mortality

Resources begin to be mobilized

Time
ASSESSMENT
Recommendation #1:

WHO needs to play the lead role in collating assessment results, coordination surveillance and surveys so that international programs are based on evidence in each large emergency.
Distribution of patient consultations by broad disease groups: ICRC field hospital January 10-31, 2005 (n=1216)

- Trauma/injury: 10%
- Gastrointestinal: 9%
- Respiratory: 22%
- Musculoskeletal: 6%
- Chronic: 16%
- Infections: 8%
- Unspecified: 10%
- Psychiatric: 9%
- Other: 7%
- Neurological: 3%

Work in progress, preliminary findings May 2005

The health impact of the Indian Ocean Tsunami: separating evidence from myth.

D. Guha-Sapir
W.G. van Panhuis
CRED, Brussels
Risk factors

- Proximity to ocean
- Ethnicity (Chinese in Banda Aceh)
- Age
- Profession (households involved in fishing)
- Time of day
- Behavior (running away) and skills (swimming)
Catholic Relief Services

Explain this to Acehenese

- Mainstreaming in their communications
- Radio spots
- Used own, private funding
DFID’s Hilary Benn proposes

- Real-time tracking of some core measures (SMART) of humanitarian impact
- Not dissimilar from a practice UNHCR adapted 20 years ago
- SPHERE consolidates consensus
Recommendation #2:

WHO should ensure that population baseline, needs and health outcome data should be disaggregated by gender, age and geographic (administrative) area.
Female to Male mortality: 1.2 – 1.9 ratio

• 23% mortality minimum, could be 30%

According to Johns Hopkins data from Aceh
Johns Hopkins SPH data on mortality rates in Aceh higher risk among young and old

Crude mortality

Age of individual

For more: See Shannon Doocy
Presentation tomorrow at 11 a.m.!!!!!!
Reproductive Health Interventions continue to receive inadequate attention or resources
Recommendation #3:

More clarity and public education in our reporting about needs, fears of epidemics, and the difference between “relief” and “recovery”
There were no second waves of disease or malnutrition.
Recommendation #4: Health data should not be manipulated for political reasons.
Darfur: Robust U.N. Response for Refugees and IDPs
World Health Organization convenes inter-agency health meeting in Khartoum
Recommendation #5:

UN OCHA should play an increasing leadership role in circulating information about needs, priorities, commitments, predictions and health outcomes in each emergency.
Evolution of the HICs: Humanitarian Information Centers

- multi-dimensional data - maps and graphs
- buy-in from UN agencies

- Weak in analytic or predictive capability by technical sector: therefore, Needs in-house statistical, epidemiologic, & other technical skills
HIC in Banda Aceh functioned as the information core of UN offices

• WHO should make use of HICs as outlet
COORDINATION
Problem:
In operations, arrangements between Organizations remain **ad hoc**

- No building on military-civil service agreements, Oslo
- Persistent lack of predictability
NAMRU

• Clinical Reference Lab quietly in NAMRU, providing disease info to WHO
• Contributing to overall surveillance

U. S. Naval Medical Research Unit
Bangladesh, 1991
Operation Sea Angel

• Again, using nearby US naval resources to bring transportation and equipment
US military alone contributes

- Philippines
- Somalia
- Small islands in Pacific
- Kurdistan (after first gulf war)
- Hurricane Mitch
- Numerous others
- Cobra Gold right now in Chang Mai
Problem:

Tensions between USG and UN over Roles and public visibility

US Govt used pre-existing contract with the International Organization for Migration (IOM) to move supplies into North Sumatra within hours
Recommendation #6:
Governments, including USG, should look to OCHA for understanding what frameworks have already been put in place, as well as WHO for norms and science.
Recommendation #7:

Governments should ensure that a population-based, comprehensive public health approach is not lost with the influx of agencies intent on providing clinical care.
Too many physicians, too few nurses.
Too many field-hospitals (many of them arriving weeks after any need was past), too little long-term support to local health systems.
Health services demands

- Tetanus: alarming but limited
- Wounds: more than other disasters
- Maternal needs: addressed?

- Continuation of TB DOTS therapy: a gap
- Measles immunization
- Sanitation
Recommendation #8:

Substantially more (ideally, most) of the supplies in disaster response and recovery should be purchased from within the country or region.
Areas of WFP Tsunami Assistance

March 8 2005

- **Somalia**
  - WFP Assessed Caseload: 31,000
  - Estimated Current Beneficiaries: 31,000
- **Myanmar**
  - WFP Assessed Caseload: 15,000
  - Estimated Current Beneficiaries: 7,300
- **Thailand**
- **India**
  - WFP Assessed Caseload: 190,000
  - Estimated Current Beneficiaries: 133,108
- **Sri Lanka**
  - WFP Assessed Caseload: 42,000
  - Initial Beneficiaries: 50,000
- **Indonesia**
  - WFP Assessed Caseload: 950,000
  - Estimated Current Beneficiaries: 914,000
  - WFP Assessed Caseload: 790,000
  - Estimated Current Beneficiaries: 510,000

Total Estimated WFP Beneficiaries: 1,646,408
Total MT dispatched: 39,483
Food aid provided by UN WFP

Cumulative Dispatches - metric tons

- Indonesia
- Sri Lanka

0 5,000 10,000 15,000 20,000 25,000
Donor presumption of a failure of food availability has often neglected local production

- In response to Hurricane Mitch, Honduras
- Indonesia
- Southern African food crisis of 2002-03
- Afghanistan
ECHO and DFID leaders in “local purchase”

- USAID has proposed to Congress a new budget for “local purchase”
UN Humanitarian aid gaps

- Sectors (water, protection, shelter)
- Groups (marginalized people, IDPs)
- Timing (response, mitigation)
- Geography (disproportionality)
- Authority, mandate, access
Water supply frequently neglected

- Often a presumption now of IRC, MSF
- Will capabilities be preserved within Oxfam, ICRC, ACF?

- In the tsunami response, Singapore, Australia and US militaries provided water generation and desalination
Transition shelter post-tsunami did not meet minimum (Sphere) standards
Problem: Fragmentation and scattering of technical interests and specialists

For instance:

• Water supply
• Shelter
• Public Works
• Nutrition
• HIV/AIDS
• Gender
• Livelihood
Options

- More authority & funds for OCHA
- More MOUs (inter-locking agreements)
- Stronger vertical authorities in field
- More money overall
- Create more specialized agencies
- More slices between agencies
- Expand UNHCR’s mandate, re-name
- Merge agencies
Recommendation #9:

Donors should question the structures they put in place 60 years ago and examine how the current set of a dozen UN assistance agencies can be restructured in order to simplify what is now a complex cross-hatch of agreements and responsibilities.
In 1995 Boutros Ghali proposed consolidation into one lead humanitarian relief organization.
• UNDRO
• DHA 1991
• UNHCR 1979, 1991, 1992, 1999 ...
• IDNDR -- ISDR “International Strategy for Disaster Reduction”
• OCHA’s future?
Recommendation #10:

Given the number of neutral health providers in areas of violent conflict, leverage their activities to demonstrate common peaceful solutions;

Evaluate at six-month intervals whether current tsunami health programs succeed as a bridge-for-peace in Jaffna and Aceh
CAPACITY
Recommendation #11:

Of international contributions for disasters, no less than 20% should be spent on prevention, local capacities, preparedness and other forms of risk reduction.
Problem: Insufficient risk reduction or mitigation

- ISDR promotes strategic thinking
- World Meteorological Organization showing leadership on early warning
- Red Cross Red Crescent movement leader in preparedness
- No recognizable operational counterpart to ISDR
Per village
the solution: Hurricane shelters (raised) in Bangladesh (which also serve year-round as schools!)
Politicians still uninformed about the essentiality of risk reduction
World Population Growth
1 AD to 1993

mid-1993: 5.508 Billion
1975: 4 Billion
1930: 2 Billion
1850: 1 Billion
1650: 500 Million
200 Million
An ocean circulation pattern known as the “conveyor” may be affected by global warming.
Georgetown focus on local capacities for disaster prevention and preparedness

- Concurrent (i.e. now) conference in Bangkok, with ADPC
- Workshop in Nairobi in Feb; Latin America in October
ask “what else?”

Multi-hazards approach

including early warning
Other infrequent, but high-impact disasters

- Krakatoa-like volcanic eruptions may hit once per century, dust (1883)
- Tunguska-like meteor impacts also perhaps once or twice a century
- Ocean level changes
- Episodes of high-velocity cyclones
- Past famines in India, China & Russia
- Irish potato famine
Excess mortality attributable to disaster

- China 1960
- Cambodia 1976
- Ethiopia 84
- Biafra 67
- Rwanda 84
- Tsunami 2004
- Bangladesh 1970
- China 1976
- Somalia 92
- Hurr Mitch
- Bam 2003
Mortality in large crises

- Ethiopia 84: 900
- Biafra 67: 800
- Rwanda 84: 700
- Tsunami 2004: 500
- Bangladesh 1970: 300
August 27, 1883
The tsunami that was generated destroyed roughly 200 villages in Indonesia
Small Island States

• Ocean levels are rising
• Disappearance of coral reefs
• Increasing salt-water infiltration

• Where a large share of the total population lives near coastline
• Caribbean, Pacific, Indian Ocean
Recommendation #12:
Create a new Millennium Dev Goal:
“Loss of lives due to disasters will be halved through implementation of multi-hazard risk reduction and preparedness”