Public Health and Complex Emergencies: New Issues, New Conditions

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ABSTRACT

Public health practice in complex emergencies has become increasingly sophisticated and well informed over the course of the past quarter century. Humanitarian relief organizations have learned many lessons in the areas of food, water and sanitation, shelter, and primary health. However, closer scrutiny from the media and funding agencies, together with changing conditions and an increasingly insecure environment, will require that changes be made.

First and foremost, nongovernmental organizations must recognize that an increasing proportion of morbidity and mortality is the consequence of widespread human rights abuses. These organizations should become more familiar with international human rights and humanitarian law, and their personnel should receive clear guidance as to how to recognize and report violations. At the same time, nongovernmental organizations will have to work more closely with military forces that have a very different organizational culture. In addition, as emergencies become more complex, nongovernmental organizations should do more to attract and retain seasoned professionals. Finally, advances in both technical and operational areas will occur only through carefully designed and implemented research. (*Am J Public Health*. 1999;89:1483–1485)

Over the past 20 years, humanitarian crises have been frequent and widespread. There have been far too many opportunities for public health workers, especially those working for nongovernmental organizations, to do a rotation through the "emergency rooms of international health," as these disasters have been called. From Cambodia–Thailand in the late 1970s to the multiple crises in the Horn of Africa through the 1980s and 1990s, to northern Iraq, Bosnia, the former Soviet Union, and the Great Lakes of Africa, a discipline—if not yet a science—of refugee health in complex emergencies has emerged.

Of course, one should not forget the "silent emergencies," those situations that have been relatively ignored by the world political powers and mass media organizations but have also been proving grounds for humanitarian workers. Internal conflicts in Burma, East Timor, Sudan, Mozambique, Angola, Colombia, Algeria, Liberia, and Sierra Leone, to name a few, have resulted in great human suffering and at the same time have contributed to the rapidly growing body of public health experience. Today, as the current crisis in Kosovo continues to unfold, relief workers have already begun to draw lessons about how to work in what seems to be a constantly changing and unpredictable environment.

What has been learned to date? From the "death camps" of Sa Kaeo and Khao-I-Dang, it became clear that health interventions could best be guided by the application of basic epidemiologic principles such as monitoring of morbidity and mortality rates, establishment of surveillance systems, and rapid response to outbreaks of communicable diseases.[1] Multiple experiences in Africa led to progress in the treatment of protein-energy malnutrition and micronutrient deficiencies.[2] The repeatedly heavy toll from measles led to the general acceptance of mass vaccination as a reflexive intervention at the start of any relief effort.[3] These and other lessons learned in the areas of health, water and sanitation, shelter, and nutrition have been summarized on several occasions and are currently being codified by the Sphere Project (www.sphereproject.org), a nongovernmental organization initiative, as minimum standards in disaster response.

Yet, despite the accumulation of knowledge and improvements in the ways in which interventions are implemented, the humanitarian community has been subjected to increasing and accelerated attack for a variety of reasons. An analysis of the Kosovo situation has even led one critic to declare "the death of humanitarianism."[4] Although reports of the demise of this good idea may be thoroughly exaggerated, it has become clear to most observers that the nature of humanitarian intervention has changed significantly. Indeed, the performance of public health workers in complex emergencies will not be optimal until it is adapted to new conditions.

The New Context of Humanitarian Interventions

What are the new conditions under which public health worders perform? To begin with the most obvious, humanitarian emergencies have become the consequence of failures in the political and diplomatic arenas. It is rare, in our times, for famine to follow crop failure caused by drought, or for mass displacement to be caused by flooding, without there being an important political component, usually involving armed conflict. The term *complex political emergency* has been coined to describe the common characteristics of contemporary situations that require humanitarian intervention. These situations involve conflict, sometimes between states but often within a single state; they are rooted in political and social discord; they are of long duration; and they engender the forced displacement of relatively large populations.[5] Most important, the victims of today's violent conflicts are not soldiers but civilians whose social, economic, and cultural identities are targeted on the basis of their ethnicity.

In addition to their important political and social dimension, today's humanitarian emergencies are characterized by 4 changes that warrant further explication: an altered epidemiologic profile, the presence of new

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actors on the intervention scene, closer scrutiny of the quality of humanitarian relief, and the recognition that in many instances solutions to prominent problems have not yet been developed. There are no surprises here; all of these factors are obvious to even the inexperienced observer.

An Altered Epidemiologic Profile

From an epidemiologic standpoint, it has become accepted practice to define as a complex emergency a situation that involves war or civil strife, food insecurity, or population displacement and that results in significant excess mortality, conventionally defined as more than 1 death per 10000 population per day.[6] On the basis of mortality alone, the Bosnian and Kosovo situations would not be defined as emergencies, though obviously they were. Consequently, it stands to reason that the current epidemiologic standard should be modified to include measures of morbidity.

Perhaps even more important, the nature of the health conditions that require professional attention has changed. Until recently, malnutrition and communicable diseases commanded most of the attention of public health authorities. As violence has come to dominate the humanitarian scene, and as civilians increasingly become the victims of war, psychological trauma and the health consequences of human rights abuses have begun to occupy a more prominent position on the list of priorities for public health workers.

In addition, over and above the need to provide care and counseling to victims of rape and other forms of sexual violence that increase in times of war, reproductive health services—consisting of emergency obstetric care, family planning, and control of sexually transmitted diseases, including AIDS—have been relatively neglected. In the Balkans, the continuation or resumption of treatment for chronic illnesses such as diabetes and hypertension for patients who had been cut off from their usual source of care or their supply of medicines was an important concern. In other words, in earlier emergencies, the emphasis was correctly placed on preserving life by minimizing preventable mortality. In today's emergencies, additional emphasis should be placed on protecting life with dignity, as expressed in the Humanitarian Charter of the Sphere Project.

New Actors on the Intervention Scene

Along with new health priorities, new actors have also emerged. Nongovernmental organizations and the military are strange—but increasingly common—bedfellows. They have found themselves sharing the humanitarian arena in situations as diverse as those in northern Iraq, Somalia, Goma, and the Balkans. Despite these frequent and close encounters, neither has become comfortable with the other just yet. Military organizations have the ability to provide protection to both affected civilians and the relief community. They have logistic capabilities that could be, but have not consistently been, of great assistance to the relief effort. Furthermore, individuals in both types of organizations are trained in many of the areas of public health expertise, from water and sanitation engineering to clinical medicine and trauma surgery, that are most needed in emergencies.

But they also have their own culture and their own mission objectives at heart. For the most part, military forces make war; at best, they are armed in an effort to keep peace. Some nongovernmental organizations have rules prohibiting guns in their compounds, believing that medical areas, and by extension public health interventions, should be both neutral and impartial. At the heart of the philosophy of nongovernmental organizations is the obligation to serve those who are in need, regardless of whose side they are on, although this precept is being increasingly put to the test.

In any event, these two players—one representing governments, the other nongovernmental, each with distinct cultures and goals—are destined, owing to the nature of today's humanitarian crises, to be in close contact with each other for many years to come. It is a marriage of convenience at best, but one to which there is no short-term prospect for separation or divorce. They should learn to live with each other more easily than is currently the case.

In contrast to the soldier, another increasing presence in the humanitarian arena is the human rights worker. With increased targeting of civilians come increasingly blatant violations of the rights codified by the existing body of international human rights and humanitarian law. However, few public health workers affiliated with nongovernmental organizations are trained to know or understand the laws that govern the situations in which they work. In fact, with few exceptions, nongovernmental organizations primarily interested in service delivery do not have clear policies to guide their personnel should they either witness directly or learn secondhand of human rights violations. This is true even when the abuses suffered by the populations they serve are important causes of psychological and physical morbidity.

Nor, it should be added, do the human rights organizations, which share many of the motives and ideals of the service delivery nongovernmental organizations, have a full appreciation of why the latter might feel reluctant, at times, to divulge information that might compromise their self-perceived neutrality. Although these actors may be philosophically closer to each other than either is to the military, improved education and training on both sides would make for smoother and more harmonious operations.

Closer Attention to Quality of Humanitarian Relief

Improved performance has become an important objective for those intervening in times of emergency. The unconscionably high rates of preventable mortality that accompanied the massive epidemics of cholera and shigellosis among Rwandan refugees in Goma in 1994 drew the attention of the media and funding agencies to the quality of humanitarian relief operations.[7] Since that time, training opportunities in emergency public health, in the form of both graduate-level degree programs and intensive short courses, have multiplied. "Professionalization" has become a catchword. Its implementation has included the development of specialized public health units within some of the larger nongovernmental organizations. As mentioned earlier, many nongovernmental organizations have joined together through the Sphere Project to elaborate and to pledge adherence to a set of minimum standards of performance.

Still, all of these efforts are voluntary. Funding for nongovernmental organizations has not yet been linked to performance. And it remains the case, interestingly, that anyone can be a health worker in an emergency; no certification, licensing, or other credential or proof of expertise is required, and there are no standards of accreditation that organizations or individuals must meet.

In addition, personnel turnover remains high. As complex emergencies become more protracted, more stressful, and more dangerous, professionals with family and financial responsibilities are increasingly reluctant to take on long-term field assignments for low pay. In emergencies such as the ongoing Kosovo situation, nongovernmental organizations often have difficulty recruiting qualified personnel to implement their programs. As a result, they may assign substantial responsibility to young, relatively inexperienced individuals.

If nongovernmental organizations are to become more professional, they will need to

take a serious look at personnel policies, salaries, opportunities for career advancement, and the like. Most important, the balance between the desire to maintain the spirit of volunteerism (and the value of this spirit in humanitarian relief work should not be underestimated) and the increasingly perceived need to professionalize will have to be carefully monitored.

Incomplete Knowledge Base for Humanitarian Interventions

No discussion of current issues in humanitarian relief would be complete without recognizing the inadequacy of our knowledge of what should be done in the face of the many public health problems that arise in emergency settings. From how to treat severe malnutrition in children and how to measure nutritional status in adolescents, to how to prevent and manage malaria and how to treat shigellosis, a large number of research questions remain. Although ethical issues need to be carefully considered in discussions of research on the world's most vulnerable populations, arguments are being made that it might in fact be unethical to refrain from attempting to find scientifically valid answers to clinical and public health problems that repeatedly arise in emergency settings.

Again, the areas of reproductive health and mental health (at both the individual and community levels) are among the most neglected. Little is known about sexual behavior under the stress of forced migration or about the adherence of overly stressed populations to the counseling of expatriate, or even local, health workers. Controversy surrounds the use of so-called Western terms such as posttraumatic stress syndrome that might result in the "branding" of sizable proportions of refugees and displaced persons as mentally ill. Recently, the World Health Organization compiled an inventory of research in humanitarian settings.[8] It is more remarkable for its sparseness than for the wealth of information it contains.

Conclusion

Relief and rehabilitation work has become a constant element of international public health activities. There is no sign that either the scope or the frequency of humanitarian emergencies involving the forced displacement of large populations will diminish in the near future. Although it is difficult to predict exactly where or when the next one will occur, it is certain that there will be many more. Because the relief community is still involved in providing assistance to populations in Kosovo, Bosnia, Burundi, Sudan, Liberia, Sierra Leone, Angola, Colombia, and many other areas on every continent, new emergencies will place even more stress on an already overburdened system.

Improving the efficiency and the effectiveness of public health interventions in complex emergencies will depend on a clearer understanding of the priorities, better coordination and cooperation in the field, a more professional approach on the part of the principal intervenors, and the reasoned and methodical pursuit of outstanding answers to the many important technical questions that remain. The lives of many of the world's most vulnerable people are at stake. □

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