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Humanitarian assistance: who should provide it and what does it involve?

In this article, **Ed England** gives an overview of what is involved in the provision of humanitarian assistance

To prevent and reduce mortality and morbidity and promote a return to normality are the primary roles of the humanitarian response to a disaster.[1] Disaster relief has come into sharp focus in the past month following the tsunami in the Indian Ocean but there are other natural disasters, including earthquakes, winds and floods, which also demand a response. The type of disaster determines the public health and medical needs of the community. In Table 1 the short-term effects of disasters and the subsequent population needs are outlined.

Disasters can also take the form of a "complex emergency", which is typically characterised by:[2]

- Extensive violence and loss of life; massive displacements of people; widespread damage to societies and economies
- The need for large-scale, multifaceted humanitarian assistance
- The hindrance or prevention of humanitarian assistance by political and military constraints
- Significant security risks for humanitarian relief workers in some areas

Health is dependent on safe water, sanitation, food, shelter, healthy environmental conditions and access to health education and information. It also depends on non-physical factors such as non-discrimination, dignity and individual self-worth. The groups most frequently at risk following a disaster are women, children, older people, the disabled and people living with HIV/AIDS. There will often be other vulnerable people, for example based on their ethnic origin or religion.

The daily crude mortality rate (CMR) is the health indicator usually used to monitor a disaster. A doubling of a country's CMR indicates a significant public health emergency, requiring an immediate response. The average baseline CMR ranges from about 0.44 per 10,000 per day for sub-Saharan Africa to approximately 0.25 per 10,000 per day for industrialised countries. When the baseline rate is unknown, health agencies aim to maintain the CMR at below 1.0 per 10,000 per day. A similar indicator is used for the baseline mortality rate in those aged under five years.[1]

Who goes to help?

The co-ordination of humanitarian assistance is usually led by the local ministry of health. Its people have the advantage of understanding the local culture, health needs and infrastructure, as well as building skills for the future. Where this is not possible, then a United Nations (UN) agency such as the World Health Organization (WHO), the United Nations High Commissioner for Refugees (UNHCR) or the United Nations Children's Fund (UNICEF) may take the role. Other agencies may take the lead where there are logistical or political difficulties at a regional, district or local level. On occasions there may be military involvement.

Following a disaster, good information exchange is essential to ensure collaboration between the huge numbers of agencies involved in providing relief. The communication processes established should allow the local population to be involved so that the existing infrastructure and skills can be developed. They should also raise awareness of and help people prepare for future disasters.

Humanitarian assistance is defined as aid to an affected population that seeks, as its primary purpose, to save lives and alleviate suffering. Humanitarian assistance must be provided in accordance with the basic humanitarian principles of humanity, impartiality and neutrality.[3]

There are many organisations involved in delivering humanitarian assistance. In the UK the Department for International Development is the government department responsible. The UN and the International Committee of the Red Cross (ICRC) are inter-governmental organisations mandated by agreements between member states. These are umbrella organisations for a range of agencies and health services, eg, the ICRC can deploy an entire hospital. Non-governmental organisations are non-profit voluntary organisations and vary in size from a few individuals to international humanitarian aid organisations such as Médicins Sans Frontières and UK-based Merlin. Each organisation is independent, will have its own mission and values, and is protected under international law (provided it meets the basic humanitarian principles of humanity, impartiality and neutrality).

Humanitarian assistance is by definition independent, provided by organisations that are neutral.[4] The military cannot traditionally fulfil this role since this would mean (or give the appearance of meaning) that the receivers of aid have taken sides. The receiver also needs to trust the intentions of the aid giver; otherwise they may be too frightened to receive aid. Both sides need to be treated equally.

The UN accepts that the conditions surrounding the delivery of humanitarian assistance in conflict are becoming increasingly difficult. Access to target populations is often hampered by security concerns and there is

Red Cross workers loading aid onto a cargo plane destined for a disaster area

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continued debate on the involvement of the military. Guidelines have been developed to facilitate the relationship between military and civil authorities.[3] When no comparable civilian alternative is available, and there is a need to meet critical humanitarian requirements, military assets may need to be used as a last resort.

The legal aspects of humanitarian work during conflicts are complex, and a useful resource has been produced by the UN Inter-Agency Standing Committee.[5] This document helps answer questions such as who is protected, under which branch of law, what type of acts are forbidden, and what constitutes a war crime.

What do the agencies do?

Following a disaster, health needs may result broadly from the following:

- Physical injury (from natural disasters, war fighting)
- Public health consequences (eg, access to aid, food, water, shelter)
- Displaced people and refugees with acute medical needs

Physical injury Following a natural disaster or conflict, injury is the major cause of morbidity and mortality. Standardised guidelines should be available to assess and prioritise patients, and to offer basic resuscitation, first aid and referral.

Field hospitals may be established when existing hospitals are not functioning. They should only be deployed when they can be integrated into the local health system and when the respective roles and responsibilities have been clearly defined.

The WHO and the Pan American Health Organization (PAHO) suggest the following essential requirements for field hospitals:[6]

- Be operational on site within 24 hours after the impact of disaster
- Be entirely self-sufficient
- Offer comparable or higher standards of medical care than were available in the affected country before the precipitating event

Field hospitals may be used to substitute or complement medical systems in the aftermath of disasters for three distinct purposes:[6]

- Provide early emergency medical care, including advanced trauma life support (this period lasts only up to 48 hours following the onset of an event)
- Provide follow-up care for trauma cases, emergencies, routine health care and routine emergencies (from day 3 to day 15)
- Act as a temporary facility to substitute damaged installations pending final repair or reconstruction, usually from the second month to two years or more (they have been successfully deployed in complex emergencies, but less successful following disasters in developing countries)

Table 1: Short-term effects of major disasters

Disaster	Public health impact of selected disasters				
	Deaths	Severe injuries	Increased risk of communicable diseases	Food scarcity	Major population displacements
Complex emergencies	Many	Varies	High	Common	Common
Earthquakes	Many	Many	Small	Rare	Rare
High winds (without flooding)	Few	Moderate	Small	Rare	Rare
Floods	Few	Few	Varies	Varies	Common
Flash floods/ tsunamis	Many	Few	Small	Common	Varies

Source: Sphere Project handbook. Available at www.sphereproject.org/handbook

Public health measures Public health measures are aimed at ensuring the greatest benefit to the greatest number of people. The prevention of communicable diseases can significantly reduce morbidity and mortality. Measures may include restoring water, sanitation, hygiene promotion, vector control, food, shelter and basic clinical care.

Preventing and controlling diseases of epidemic potential is more important than hospital care. Measles is highly contagious, especially in overcrowded conditions, and is associated with a high mortality rate. The mass vaccination of children to prevent measles is often a high priority, especially among displaced people and those affected by conflict.

Pharmacy trained staff on the ground have a role in ensuring that reserve stocks of essential medicines, and that medical supplies and vaccines are available or can be obtained rapidly in preparation for an outbreak of communicable disease.

Acute medical needs The WHO New Emergency Health Kit 98 (NEHK 98) is often deployed.[7] The kit is designed to meet the first primary care needs of a displaced population with no established medical facilities. It is important to appreciate that during the initial humanitarian response, these kits might not be used under the direct supervision of health care professionals. NEHK 98 includes medicines, disposables and instruments to support 10,000 people for a three-month period, as well as clinical guidelines and treatment manuals.

The aim of the use of kits is to encourage standardisation of medical material to allow a quick response to the need. The medicines chosen are based on the recommendations of standard treatment regimens. The medicines may not be those that pharmacists in the UK might expect, because although the choice is dictated by clinical need, consideration is also given to dosage regimen (for compliance), stability in tropical conditions, packaging issues and cost. For example syrups are not included for children because of their instability, short shelf-life after reconstitution, volume and weight.

Many countries now have a standardised essential drugs list. This is the list of medicines considered necessary for the health of the population, and so should be available at all times. If the country does not have a list then the guidelines established by the WHO or the UNHCR should be followed. A key role for people with pharmacy training is to ensure the consistent supply of essential drugs. Drug donations are only accepted if they meet the internationally recognised guidelines,[8] and donations should generally only be sent with the prior consent of the recipient. The guidelines provide practical advice on this area of work.

A minimum initial service package for reproductive health is also defined. This is the equipment and services for the provision of a comprehensive reproductive health service, including midwifery kits to ensure the clean and safe delivery of babies, as well as services to prevent the transmission of HIV/AIDS and to manage the consequences of gender-based violence. A UN Population Fund kit facilitates the implementation of this package.[9]

Mental health is another area where intervention must be considered and medicines made available from the essential drugs list.

Chronic needs People with chronic diseases must be identified and life-saving therapy should be continued. The medicines used to treat chronic conditions should be consistent with the essential drugs list. This can be the cause of dilemma, since the kits have essentially been designed to meet the needs of patients in the developing world, and the medicines that patients are taking or prescribers wish to use may not be available.

It is not appropriate for practitioners to commence treatment of individuals with chronic diseases with medicines that are not sustainable after the humanitarian assistance has finished.

Guidelines and standards

The Sphere Project[1] is owned solely by NGOs and is based on the core beliefs that all possible steps should be taken to alleviate human suffering arising out of calamity and

Panel 1: Useful websites

- **Department for International Development**
  www.dfid.gov.uk
- **Drug Donations**
  www.drugdonations.org
- **European Community Humanitarian Office**
  europa.eu.int/comm/echo/index_en.htm
- **Médicins Sans Frontières**
  www.msf.org
- **MERLIN (Medical Emergency Relief International)**
  www.merlin.org.uk
- **Pan American Health Organization Disasters and Humanitarian Assistance**
  www.paho.org/english/dd/ped/home.htm
- **The Sphere Project**
  www.sphereproject.org
- **World Health Organization Essential Drugs and Medicines Policy**
  www.who.int/medicines/default.shtml

conflict and that those affected by disaster have a right to life with dignity and therefore a right to assistance. According to the website (see Panel 1), Sphere is three things: a handbook, a broad process of collaboration and an expression of commitment to quality and accountability. The key tool is the handbook.

The Sphere standards state that people should have access to clinical services that are standardised and follow accepted protocols and guidelines. When agencies become involved in providing health care, they should adhere to the standards and guidelines of the country where the disaster response is being implemented. This can cause ethical dilemmas for many personnel from wealthy countries who, with their evidence-based backgrounds believe that they have an obligation to treat a patient to the best of their ability rather than to the local standard. However this action may cause resource difficulties following the departure of the relief agency, and the health intervention may not be sustained. Where the local guidelines do not reflect evidence-based practice, they should be updated in consultation with the lead health authority.[1]

Implications for UK pharmacy practice

Many people in the UK are involved in supporting the work of humanitarian agencies. However disasters can also happen locally — natural disasters, stadium accidents and terrorism. Some questions that could be asked include:

- Are the local disaster plans up to date, and do they reflect current practice?
- What are the local plans for managing medicines?
- Are pharmacy trained personnel empowered and trained to administer medicines?
- Are guidelines in place to meet patients' first aid requirements?

This is just a brief overview of what is a complex process. There is a substantial amount of information available, and some useful websites are given in Panel 1.

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