Public Health in Times of War and Famine

What Can Be Done? What Should Be Done?

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I n this issue of the Journal, 2 articles and a letter to the Editor argue, yet again, that war and public health are incompatible pursuits. The article from Guinea-Bissau by Gustafson et al is an elegant analysis of what happens when patients with a chronic disease, in this case tuberculosis, are forced to interrupt or abandon treatment because of war, civil strife, or other societal upheaval. By comparing the experiences of patients with tuberculosis forced to flee from the capital city of Bissau because of violent fighting with those who had completed an entire course of treatment during peacetime in the year before the fighting, the authors are able to estimate a war-specific relative risk for tuberculosis mortality of 3.1 (95% confidence interval, 1.20-8.12). In other words, patients with tuberculosis whose treatment was disrupted because of war were 3 times as likely to die as those who were fully treated in peacetime.

The notion that hundreds of thousands, perhaps millions, of people die each year, not from direct acts of violence but because the various forms of war deprive them of access to health services, is not a novel finding. Health professionals will continue to be frustrated by factors beyond their control that prevent them from practicing medicine and public health to the best of their ability during war, mass violence, and disasters. Put simply, for patients to fulfill their “right . . . to medical care and necessary social services,” they must have access to those services and health workers must have access to those patients. No matter how difficult or seemingly hopeless the situation may seem, there must be adequate “humanitarian space” to allow for an assessment of the needs of the population and unhindered distribution of goods and services in a safe and secure environment. However intuitive that may seem, it has become clear that repeated documentation of the toll that war and violence take on civilians is necessary and that strong and effective advocacy in both the medical literature and the lay press is part of the prescription for this insidious problem.

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See also pp 531, 563, and 599.

Studying the health consequences of wars, conflicts, and disasters has revealed that tuberculosis is not usually one of the major causes of mortality in the acute phase of complex emergencies. Malnutrition, measles, diarrheal diseases, respiratory tract infections, and malaria are all firmly established causes of normally preventable mortality in these settings. Gustafson et al make no mention of the toll taken on the displaced population of Guinea-Bissau by these conditions. However, Aaby et al have reported that childhood mortality in the displaced population during the conflict was as high as 3.0% in a 6-week period.

Also in this issue of THE JOURNAL, Salama and colleagues make 2 essential points in their description of the famine that occurred in eastern Ethiopia last year. First, even though the epidemiology of complex emergencies has been described previously, important causes of morbidity and mortality are still being identified. Adult malnutrition in complex emergencies has been ignored since the end of World War II. Although the diagnosis and treatment of moderate and severe malnutrition of children has been a mainstay of medical care in emergency settings, neither widely accepted anthropometrical criteria nor treatment recommendations are available for adults. However, in Sudan, Somalia, and now in Ethiopia, the severity of this problem has been documented.

Identification of adult malnutrition and other problems for which solutions are yet to be found underscores the need for continued research into how best to meet the medical and public health needs of populations affected by war and other disasters. In the areas of reproductive health (including human immunodeficiency virus/acquired immunodeficiency syndrome), psychosocial health, and surgical care, among others, there is much to learn before safe and effective interventions can be made available to affected populations, assuming those who provide humanitarian assistance have adequate access. Ethical considerations in conducting research in highly vulnerable, dependent populations must remain paramount. Continuing to identify important public health problems and documenting the results of different interventions are essential to provide the best health care to the most needy people.

However, as Salama et al point out, simply having knowledge is not sufficient; putting it into practice remains a major challenge. The humanitarian intervention in Gode, Ethiopia, was quite late, and most deaths occurred before the international community intervened. In the early stages of the relief effort (the later stages of the famine), mortality—largely due to measles and malnutrition—actually increased. Measles has been well documented as a leading cause of mortality in emergency settings and measles vaccination has long been recommended as an early health intervention. The report by Salama et al attributes this increase in mortality to the presence of unvaccinated children in crowded, centrally located sites from which relief goods were being distributed. In Gode, failure of the international relief community to apply well-known, well-accepted principles of public health interventions in complex emergencies resulted in a high rate of preventable childhood mortality.

It is exactly this kind of inadequate relief effort that the Sphere Project is trying to prevent. As Salama et al describe in their letter in this issue of THE JOURNAL, the field of humanitarian intervention is not overseen by any regulatory body, neither certification nor licensure is required to practice, and there is no formal system of evaluation of either individual or organizational performance. The Office of the United Nations High Commissioner for Refugees (UNHCR) has a mandate to protect and safeguard the well-being of those who qualify as refugees under the 1951 United Nations Convention relating to the status of refugees and related international agreements. However, by definition refugee status is accorded only to those who have crossed an international border. The needs of internally displaced populations such as those described in this issue of THE JOURNAL are not routinely addressed.

The Sphere Project is the collaborative effort of a large number of nongovernmental organizations (NGOs)—the major implementers of humanitarian assistance. After 2 years of deliberation, the principal product of the Sphere Project is a handbook that proposes minimum standards in 5 technical areas: water supply and sanitation, nutrition, food aid, shelter and site planning, and health services. Adherence to these standards is intended “to increase the effectiveness of humanitarian assistance, and to make humanitarian agencies more accountable.” Central to the understanding of how these standards should be applied is the Humanitarian Charter, which asserts that all people in all circumstances have a right to life with dignity and to protection and assistance as spelled out in international human rights and humanitarian law. In short, the Sphere Project, without proposing any regulatory or oversight mechanisms, is an effort by the NGOs that are an essential component of the relief community to establish performance standards for themselves.

However, the Sphere Project recently has been subjected to criticism by a number of NGOs. The major flaws of the Sphere Project, according to these NGOs, are not found in its content—as one critic puts it, “who could deny that aid recipients have a right to quality care, or that humanitarian action must, by definition, conform to certain principles?” Rather, objections are raised to what is perceived as an excessive emphasis on the technical nature of the standards and a relative lack of concern for the fundamental obligation of the international community to provide protection and security, over and above the mechanical provision of adequate quantities of food, water, and shelter, to those whose lives are imperiled not only by need, but by circumstance. According to Terry, “a vaccination card or a full belly does not protect against refoulement or attack.”

In addition, objections are raised that technical standards risk being taken too literally and interpreted too strictly,
are recognized leaders in the field and their own suggested technical standards are among the strongest critics of the Sphere Project. This imbalance is clearly not its intent. Some of the NGOs that are among the strongest critics of the Sphere Project have voiced their objections should assert their leadership by continuing to participate in the process until they, and others, are convinced that all valid concerns have been met and appropriately addressed. A strong, effective, and sound set of humanitarian and technical guidelines would contribute greatly to the ability of the humanitarian organizations to protect and to assist those most vulnerable populations whose lives are all too frequently endangered by war and its consequences.

REFERENCES