

Stop propagating disaster myths

The international response to the recent tragic earthquakes in Turkey, Greece and Taiwan reinforces the need to reassess the myths and realities surrounding disasters, and to find ways to stop these destructive tales. Most of those myths cover the fear of epidemics and the place of external assistance in the rescue effort.

The myth that 'dead bodies cause a major risk of disease', as reiterated in all large natural disasters from the earthquake in Managua, Nicaragua (1972) to Hurricane Mitch and now the earthquakes in Europe and Asia, is just that, a myth. The bodies of victims from earthquakes, other natural disasters and conflicts do not present a public health risk of cholera, typhoid fever or other plagues mentioned by misinformed medical doctors or humanitarian players. In fact, the few occasional carriers of those communicable diseases who were unfortunate victims of the disaster are far less of a threat to the public than they were while alive. In those countries where these diseases were, for all practical purposes, not present prior to the disaster, they cannot appear and spread.

Often overlooked is the unintended but dramatic social consequence of the precipitous and unceremonious disposal of corpses. It is just one more severe blow to the affected population, depriving them of their human right to honor the dead with a proper identification and burial. The legal and financial consequences of the lack of a death certificate will add to

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the suffering of the survivors for years to come. Moreover, focusing on unnecessary and, in any case, ineffective measures such as the superficial 'disinfection' with lime or the often partial cremation of corpses requires important human and material resources that should instead be allocated to those who survived and remain in critical condition.

Our experience in the aftermath of the earthquake in Mexico City (1985) showed that health authorities and the media can work together. They have informed the public and made possible the identification of the deceased and the return of the bodies to the families in a climate free of unfounded fears of epidemics.

The unreasonable fear of epidemics is not only manifested with regard to cadavers. For a long time WHO has discouraged the post-disaster improvisation of mass immunization campaigns recommending instead that countries take advantage of the temporary gathering of normally scattered populations to improve the coverage of *normal* immunization policies. Following natural disasters,

external or foreign medical teams rush to administer any available vaccine (generally donated) with the excuse: 'It can't do any harm,' or more candidly, 'we have nothing else to do'. Wrong! Unplanned, improvised, and poorly supervised mass campaigns are not without medical risks.

However, as with the disposal of bodies, the primary negative result is the false feeling of security we misleadingly impart. The result is the population is distracted from the only effective measures: improving sanitation, controlling food and water quality.

External assistance has its own myths that we conveniently maintain. Reports that local populations affected by natural disasters are helplessly waiting for the external world to save them are also false, especially in countries with a large -but unevenly distributed- medical population. In fact, only a handful of survivors owe their lives to external (from other regions of the affected country) or foreign teams. Most survivors in earthquakes, cyclones and floods owe their lives to neighbors and local authorities. When foreign medical teams arrive, most of the physically accessible injured have received some medical attention.

Western medical teams are not necessarily most appropriate to the local conditions prevailing in many developing countries. How many lives might foreign search and rescue teams (SAR) in Turkey (1999) have saved? The most sophisticated



WHO recommends that the temporary gathering of normally scattered populations be used to improve the coverage of normal immunization policies.



In a disaster it is not unusual for volunteers to join with rescue teams to search for victims.



above left and right: *Unsolicited material competes for space and takes time to identify for usefulness*

and costly teams coming from far away only saved a couple of lives. SAR is an acute example of quickly diminishing returns where time is everything! What has been the cost? Certainly, foreign investment in building the local capacity would have been more effective but less mediatic.

As a professional disaster manager for the last twenty-five years, the press coverage of the recent earthquakes in Europe (especially in Turkey) leaves me with a sense of déjà vu. International rescue teams rushing in are made to look as though they are saving victims neglected by incompetent or corrupt local authorities. We saw the same thing after major earthquakes and hurricanes in the countries served by the Pan American Health Organization (PAHO) in the Americas.

Disaster-stricken countries appreciate external assistance, and it can do a lot of good when directed to real problems. Unfortunately, too much of the assistance is directed to non-issues or myths.

For example, a common myth is that 'any kind of international assistance is

needed', and it's needed now, while our experience shows that a hasty response that is not based on familiarity with local conditions and meant to complement the national efforts only contributes to the chaos. It is often better to wait until genuine needs have been assessed. Many also believe that disasters bring out the worst in human behavior, but the truth is that while isolated cases of antisocial behavior exist, the majority of people respond spontaneously and generously.

The myth that 'the affected population is too shocked and helpless to take responsibility for its own survival' is superceded by the reality that on the contrary, many find new strength during an emergency. This is evidenced by the thousands of volunteers who spontaneously united to sift through the rubble in search of victims after the 1985 Mexico City earthquake or the one in Turkey. Perhaps this cross-cultural dedication to the common good of so many local volunteers and institutions, without red tape or petty institutional turf fights, keeps alive our faith in humankind and society.

This generous response far outweighs opportunistic behavior.

One myth trespasses on all types of disasters: natural, or complex, or those resulting from armed conflicts: 'Send any type of donation—it is needed immediately!' There is not one seasoned relief worker without his or her bag full of anecdotes on inappropriate donations. As an inter-governmental agency serving national institutions we have seen, in

each international disaster, the management problems caused by the flood of unsolicited, inappropriate or useless supplies that clog the distribution channels, competing for space and transportation with the critically needed items. The medical field is particularly prone to these errors: Expired medicines, partially used household prescriptions, and samples or inappropriately labeled products may represent a substantial portion of the health donations.

At the request of the affected countries, the WHO regional office for the Americas developed 'SUMA' a computer program, a training package and an operational capability at national and international levels to sort, classify and inventory all supplies for humanitarian assistance. This skill imparted to all countries in the Americas (over 1,500 trained national personnel) has now found a new application in the East Timor crisis. As in past disasters, supplies of any kind, good and bad, are stockpiled in two warehouses in Darwin and are trickling down to Dili, East Timor. The humanitarian sector has no spare logistical capacity to waste on unneeded supplies. To compound the humanitarian coordinators' problems, no comprehensive information was available on what actually was in the warehouses or in the pipeline, since the supplies belong to a large array of agencies and non-governmental organizations. SUMA provided the tool to collectively manage large amounts of miscellaneous supplies, regardless of their ownership and share information among all parties.

It is an interesting contribution from WHO to the overall management of donated supplies, but only a palliative solution. The still unaddressed cause lies in the misinformation the public receives on what is needed and, more important, what is NOT needed. The myth of a



Disaster victims need time to identify and grieve over relatives and friends.

population thankful for any kind of supplies is not sustainable in even the most acute famines in Africa. Starving children cannot adjust to most food items. Likewise, it is not sustainable in even the most dramatic earthquakes.

The myth that 'things go back to normal within a few weeks' is especially pernicious. The truth is that the effects of a disaster last a long time, definitely longer than the attention span of the public. Disaster-affected countries deplete many of their financial and material resources in the immediate post-impact phase. The greatest need for external assistance is to restore normal primary health care services, water systems, housing, and income-producing work. Social and mental health problems will appear when the acute crisis has subsided and the victims feel (and often are) abandoned to their own means.

Proper resumption of public health

services, such as immunization and sanitation measures, control and disposal of waste, and special attention to water quality and food safety, will ensure the safety of the population and of relief workers.

It is essential that the press and the donor community are aware of what is good practice and what is malpractice in public health emergency management. Past natural and complex disasters in the Americas and elsewhere have shown the need for international contributions in cash and not in kind.

There should be built in flexibility to use these for rehabilitation, if the need arises. Do not rush humanitarian organization in a high visibility job at the cost of the welfare of the victims. This ensures that allocation of resources is field-driven by evidence of what is needed on-site.

The civilian population in many disas-

ters does not need used clothing, household or prescription medicines, blood and blood derivatives, medical or paramedical personnel or teams, trauma field hospitals and airlifted modular medical units. They want, as do any victims of disasters, to rebuild safer houses, have their 'normal' health problems attended at the health center, put their kids in school and get on with their lives. Unilateral contributions of un-requested goods are inappropriate, burdensome, and divert resources from what is needed most.

There are lessons to be learned. While it is true that local authorities are generally insufficiently prepared, who is ever ready for a disaster of this magnitude? The United Nations, the World Health Organization and NGO's should have done more to strengthen the local capacity, but with what resources?

Donor countries have spent millions of dollars to dispatch search and rescue teams—who arrived after the most critical first hours or days—to countries where thousands of local medical doctors volunteered their services. A small part of this money could have been more effectively applied to preparedness and prevention activities.

We need to educate donors just as we need to educate potential victims of disasters. A little preparedness can go a long way toward alleviating the 'secondary' disasters caused by international assistance that are often visited on countries. Increased international funding for disaster preparedness and prevention in the third world could help matters.

If donors would commit now to strengthen the local capacity to respond to future natural disasters in vulnerable countries, and learn what is important and what is futile when helping countries, the world would be better off.



above and top: SUMA organised and classified material



above: SUMA training session